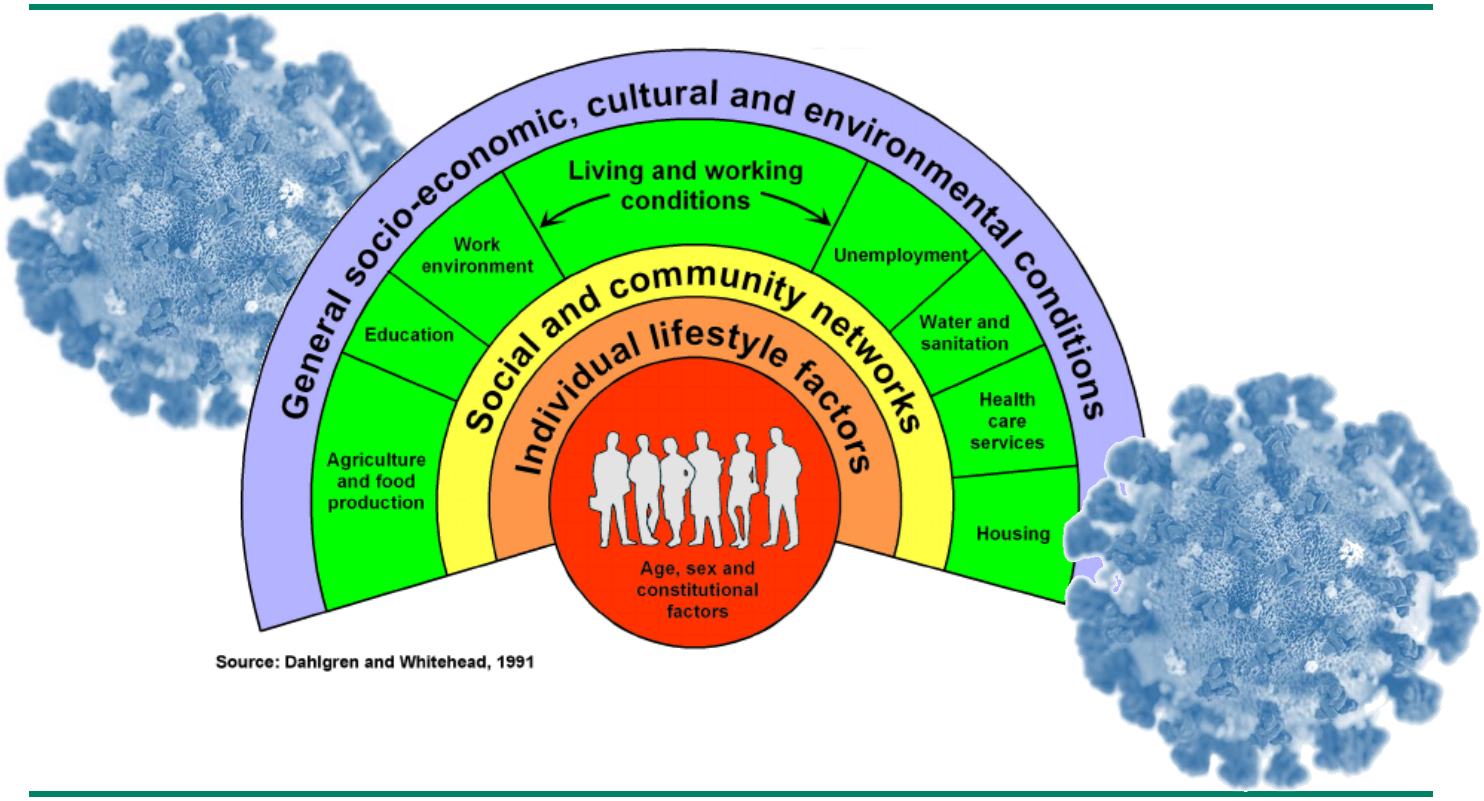
Our Tameside JSNA Summary: Post COVID-19 Pandemic Inequalities and Recovery in Tameside



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Tameside Metropolitan Borough

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Foreword

“As the success of the COVID-19 vaccination programme sets the UK on a course towards recovery, it is essential to learn the lessons of the past 18 months. What started as a health crisis rapidly developed into an economic emergency, with government taking unprecedented action to protect people’s lives and livelihoods. The pandemic has shown that health and wealth are inextricably connected. A sustainable recovery needs to create a stronger, more resilient economy and will require purposeful commitment to ‘level up’ health and reduce the stark inequalities exposed by the pandemic.” (The Health Foundation, 2021)

COVID-19 has had a significant impact on public health and wellbeing across the UK, and Tameside is no exception. While the full impact of the pandemic on public health inequalities is still ongoing, with this paper outlining the current position, some evidence suggests that certain groups in Tameside have been disproportionately affected by the pandemic. These groups are as follows:

- Deprivation/Deprived Groups: The pandemic has had a greater impact on people living in more deprived areas of Tameside, who are more likely to have underlying health conditions and work in low-paid, high-risk jobs that exposed them to the virus, therefore with a higher risk of developing long-covid. There is also evidence to suggest that people in more deprived areas are less likely to have access to the support they needed to manage the impact of the pandemic on their physical and mental health.

- Ethnicity: ethnic minority communities in Tameside have been disproportionately affected by COVID-19, with higher rates of hospitalisation and mortality compared to the white British population. This is likely due to a combination of factors, including underlying health conditions and socio-economic factors.

- Mental Health: The pandemic has had a significant impact on mental health and wellbeing across the UK and Tameside is no exception. There are concerns that the pandemic has exacerbated existing mental health inequalities, with people from areas that are more deprived and certain ethnic groups being at higher risk of developing mental health problems.

- Health Care Access: The pandemic has disrupted healthcare services, leading to delays and cancellations of non-urgent appointments and procedures. This may have disproportionately affected people from more deprived areas of Tameside who are less likely to have access to private healthcare and may have to rely on the overstretched NHS.

- Employment: The pandemic has had a significant impact on employment across the UK, with certain industries being hit harder than others are. People from more deprived areas of Tameside may be more likely to work in these industries and be at greater risk of losing their jobs or experiencing financial hardship.

- Like many other areas in the UK and around the world, the subsequent fallout of the COVID-19 pandemic has had a significant impact on Tameside's economy. The pandemic has led to disruptions in the global supply chain, reduced consumer spending, and forced many businesses to close their doors temporarily or permanently.

- According to the latest available data, Tameside's unemployment rate has increased since the pandemic began, reflecting the impact of job losses and reduced economic activity. However, the rate of increase has been lower than the UK average, and there are some signs of recovery.

The wider determinants of health are a diverse range of social, economic and environmental factors, which influence people’s mental and physical health. Variation in any of these factors constitutes social inequality, and in turn therefore drives health inequalities.

Like many areas across England, Tameside experiences health inequalities that disproportionately affect certain population groups. Some examples of public health inequalities, which have a bigger than proportionate effect in Tameside include:

- Deprivation: Tameside has higher levels of deprivation compared to the national average, and people living in more deprived areas tend to have poorer health outcomes. For instance, there are higher rates of smoking, obesity, and mental health problems in more deprived areas of Tameside.

- Ethnicity: There are significant health inequalities between different ethnic groups in Tameside. For example, the South Asian community has higher rates of diabetes and cardiovascular disease compared to the white British population.

- Age: Older people in Tameside may face health inequalities due to social isolation, lack of access to health services, and age-related health problems such as dementia.

- Gender: Women in Tameside may experience health inequalities related to reproductive health, with higher rates of teenage pregnancy, cervical cancer, and breast cancer.

- Disability: People with disabilities may experience health inequalities related to access to healthcare, social support, and employment opportunities.

Addressing these inequalities requires a multifaceted and multiagency approach that addresses the underlying social determinants of health, such as poverty, housing, and education, as well as improving access to healthcare services and promoting healthy behaviours. This will involve campaigning to the highest levels of the UK government and communicating messages all the way to grass root community clubs and voluntary organisations. In addition, this will be a long and challenging road, taking investment over time to address the entrenched nature of the inequalities within Tameside.

Summary and Key Findings

Across Tameside, some of the biggest public health challenges highlighted within this document include:

- Alcohol Misuse: Tameside has high levels of alcohol misuse, with associated problems such as liver disease, cancer, and mental health issues. There is also a high level of alcohol availability with a high volume of alcohol sold via off-sales. These issues lead to Tameside having poor substance misuse outcomes as a whole compared to other authorities nationally.

- Asthma: Tameside has the highest hospital admission rate in under-19s for asthma in the country, which is indicative of poor air quality and other environmental factors which contribute to this, and uncontrolled asthma which can result in admissions, where proactive care and support is not accessed.

- Mental Health: Tameside has higher than average levels of depression and anxiety.

- Obesity: Tameside has a higher-than-average obesity rate, with approximately 1 in 3 adults being classified as obese. This can lead to a range of health problems, such as diabetes, heart disease, and some forms of cancer, all of which Tameside is significantly worse than the England average and are drivers of the high rate of early preventable mortality in Tameside.

- Other long tern health conditions: owing to significantly higher prevalence of a range of risk factors in Tameside compared to the national average such as alcohol consumption, tobacco, there is a greater prevalence of long-Term conditions. Tameside is significantly worse in both the prevalence of long term conditions and Healthy Life Expectancy (especially for women), which is an indicator of how long you could expect to live in 'good' health.

- Poor Air Quality: Air pollution is a significant public health problem in Tameside, with some of the highest levels of particulates (which cause poor air quality) in Greater Manchester, which have the potential to cause respiratory problems, heart disease, and other health issues. Given the additional mix of busy roads and densely populated houses, this in turn contributes to the growing health problems throughout Tameside.

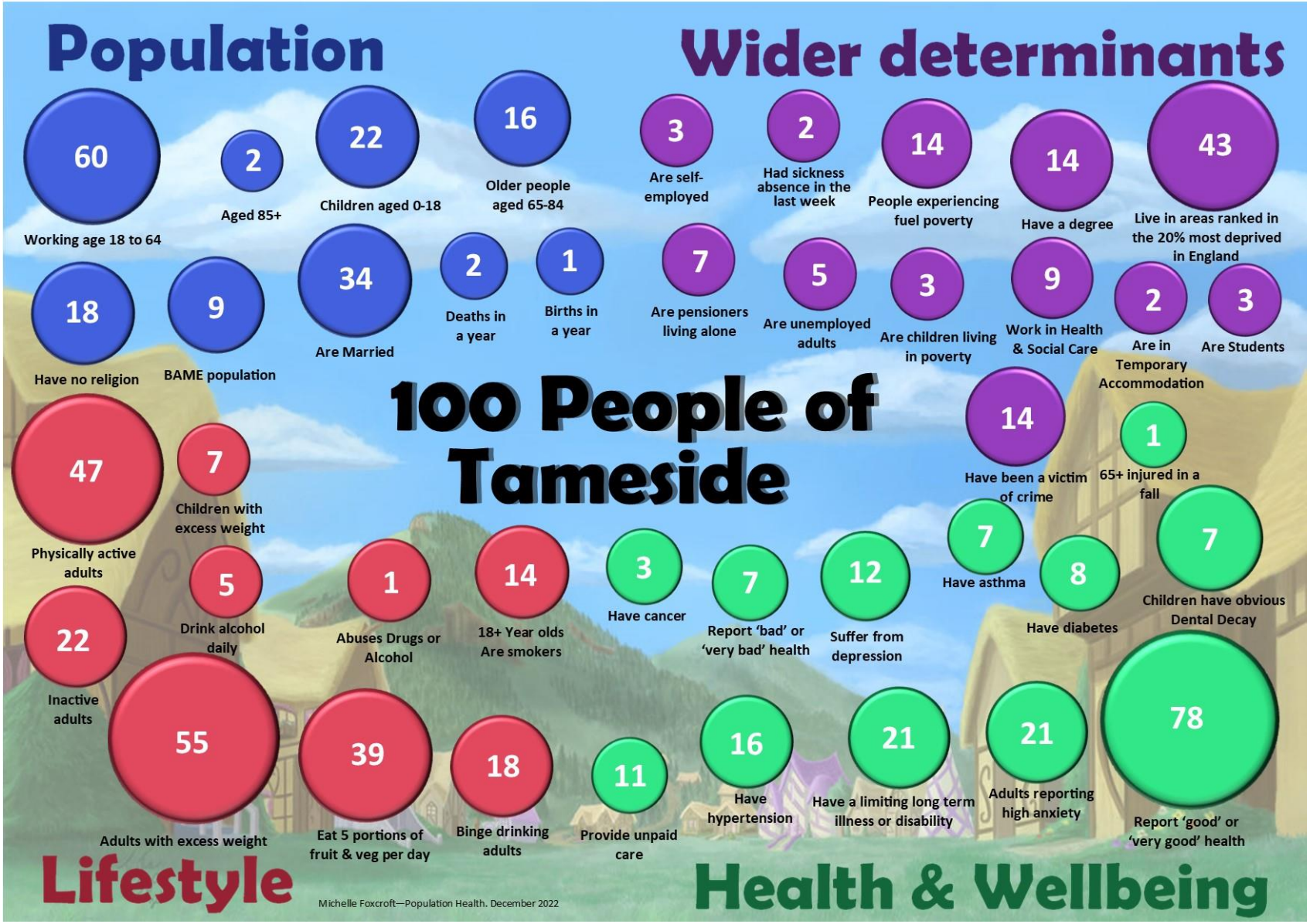
- Smoking: Despite a decline in smoking rates across the UK and in Tameside, Tameside still has a high proportion of smokers and those who live in more deprived areas are still disproportionately affected. Smoking is a leading cause of preventable illness and premature death, which Tameside is an outlier being one of the worst local authorities for outcomes around preventable and early mortality.

- Education, Employment & Skills: Evidence shows that there is an increasing proportion of worklessness across Tameside, combined with a high proportion of young people not in education, employment or training (NEET), lower levels of NVQ level 3 and 4 attainment, lower earnings, and lower proportion of jobs paying the real living wage, compared to other areas.

- Food: There are increasing numbers of food banks and food pantries in Tameside, which a strong correlation with areas of greater deprivation. There is also a much higher density of hot food takeaways in more deprived areas and high levels of food poverty across the borough compared to similar areas.

Efforts are being made to address these issues through various public health interventions, including education campaigns, policy changes, and community outreach programs. This document highlights the current scale of the challenge, amidst the backdrop of a post COVID-19 recovery and discuss areas for future work and research to improve the lives of everyone in Tameside.

Background and Demographics

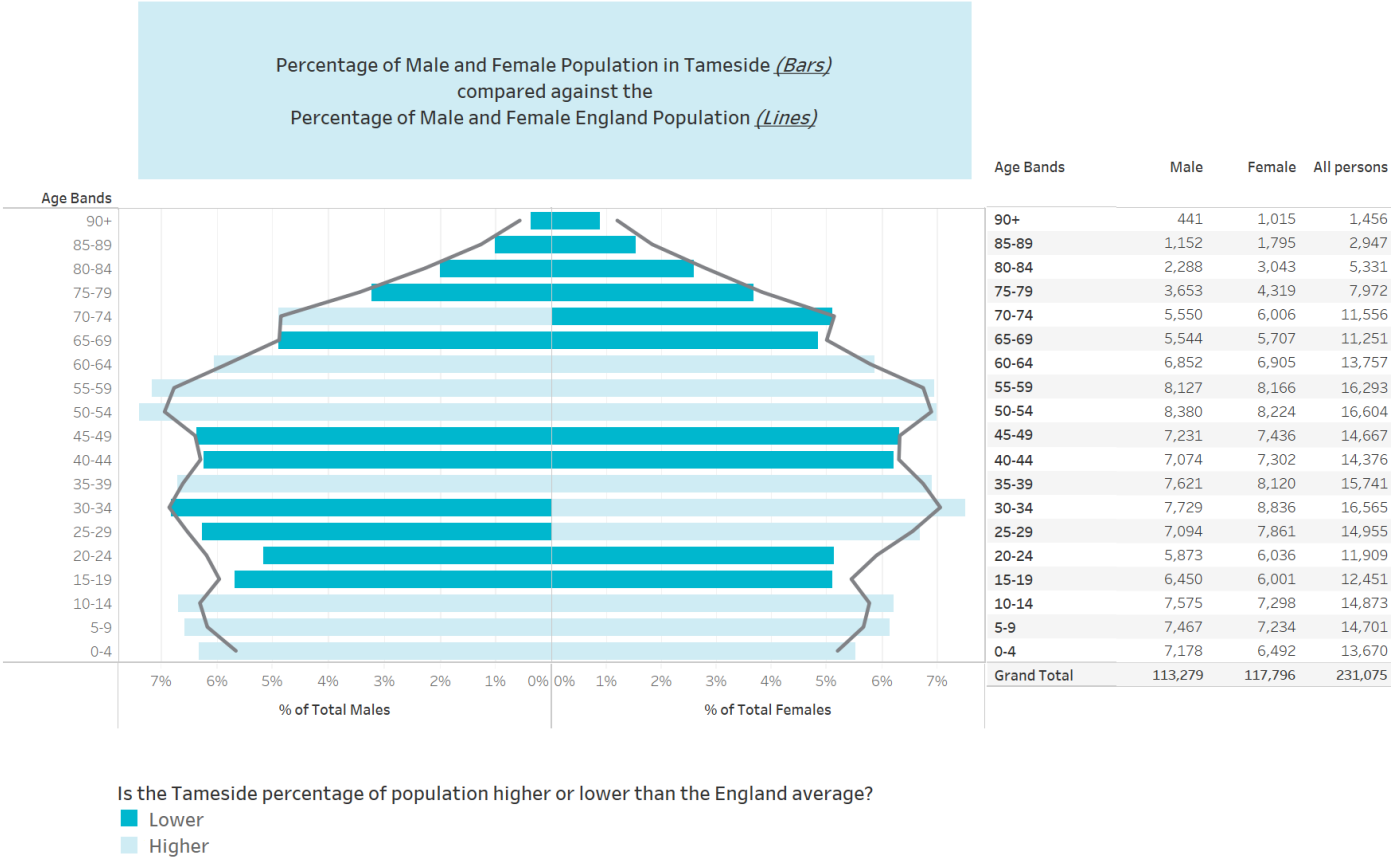


The infographic contained on the previous page highlights some of the overall population and demographic information, based on if Tameside existed with only 100 people. This is to display what proportion or percentage of people have the given characteristic. They could also fall into more than one group for example aged 65-84, experiencing fuel poverty and obese.

Our Population

The usual resident population of Tameside was 231,075 on Census Day, 21st March 2021; which has grown 5.4% over the last decade (since the Census 2011). This growth however is slower than the national population growth (6.3%). Overall, there were 113,276 men (49% of the overall population) and 117,797 women (51%) living in Tameside in 2021. This is similar to 2011, when 49.1% of the population were male and 50.9% were female.

Tameside Population by Gender, compared with the England Average



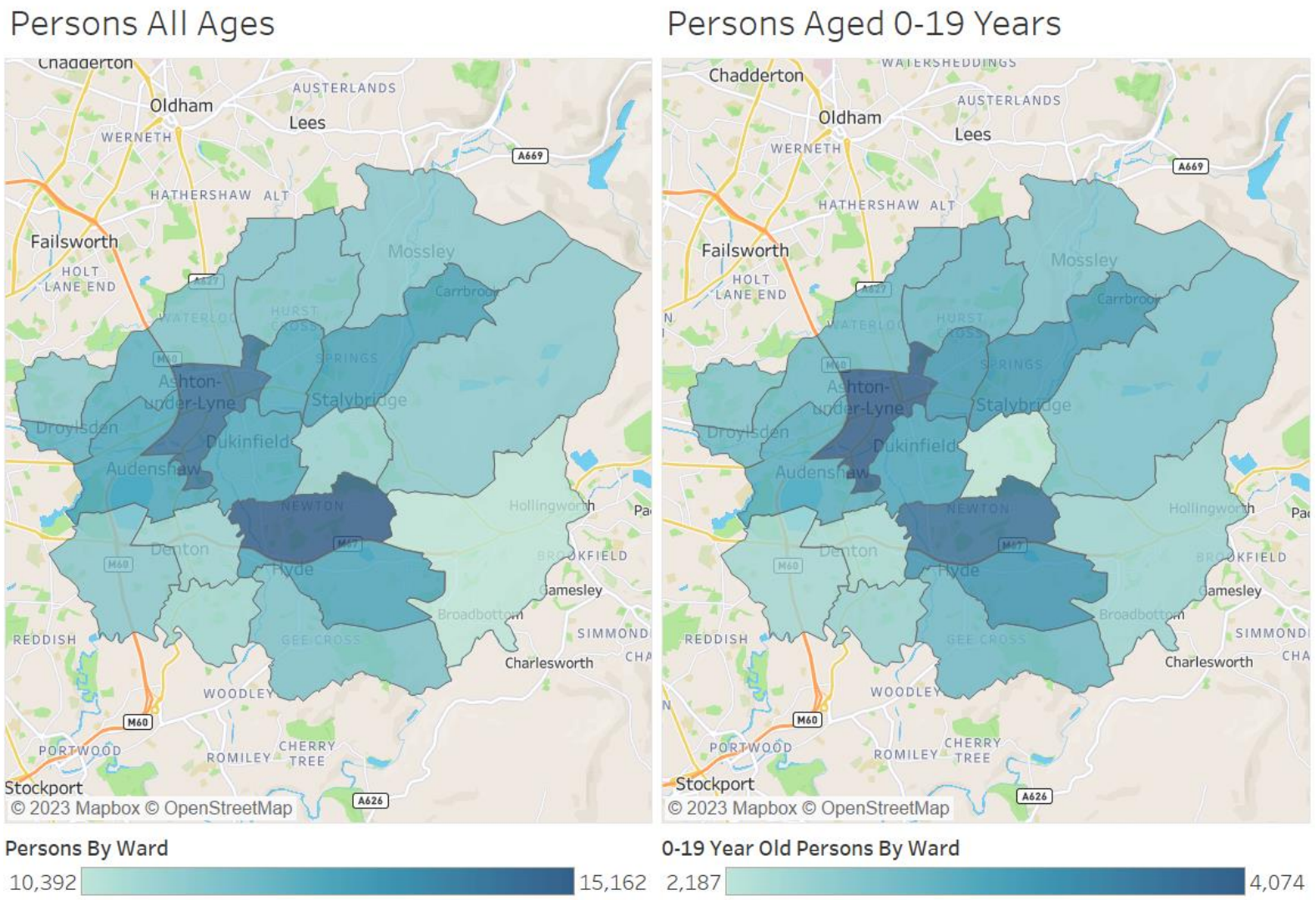
Age Bands	Male	Female	All persons
90+	441	1,015	1,456
85-89	1,152	1,795	2,947
80-84	2,288	3,043	5,331
75-79	3,653	4,319	7,972
70-74	5,550	6,006	11,556
65-69	5,544	5,707	11,251
60-64	6,852	6,905	13,757
55-59	8,127	8,166	16,293
50-54	8,380	8,224	16,604
45-49	7,231	7,436	14,667
40-44	7,074	7,302	14,376
35-39	7,621	8,120	15,741
30-34	7,729	8,836	16,565
25-29	7,094	7,861	14,955
20-24	5,873	6,036	11,909
15-19	6,450	6,001	12,451
10-14	7,575	7,298	14,873
5-9	7,467	7,234	14,701
0-4	7,178	6,492	13,670
Grand Total	113,279	117,796	231,075

Between 2011 and 2021, all age groups increased in Tameside except for children aged under 19, reflecting a decade of falling birth rates; and people aged 80 and over, bucking a national trend of an increase in this area. However when compared to the current national average Tameside does have a higher percentage of the population between the ages of 0-14, showing that although there has been a decline in the birth rates, Tameside still has a higher percentage of the population than nationally.

Tameside saw the North West's third-largest percentage rise in the proportion of lone-parent households (from 12.8% in 2011 to 13.8% in 2021).When discussing inequality this relates to a household adversity which increases the risk of a child's likelihood of adverse childhood experiences (ACE). (UCL Insitiute of Health Equity, 2015). ACE's are situations which lead to a higher risk of children and young people experiencing damaging impacts on health, or other social outcomes, across their lives and ultimately perpetuate a cycle of intergenerational inequality.

Since 2016, the rate of population growth has slowed. This is in-line with the national population, which last year grew at its slowest rate for 20 years. In Tameside, growth has been mainly concentrated in the Hyde and Ashton areas, especially among young people under 19.

Tameside Population by Ward



Given that the population of children has grown in the more deprived areas of our borough, this in turn leads to ACE's for children and the cycle of inequalities experienced by each generation.

2018 Based Population Projections of Key Age Groups and Dates

Percentage Growth of Persons -
When compared to 2018

Year	0-14	16-64	50+	65+	80+	90+
2018	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
2020	1.2%	-0.2%	2.8%	1.3%	3.9%	2.5%
2022	1.8%	-0.1%	4.6%	3.8%	6.9%	1.7%
2025	0.9%	1.9%	3.4%	6.4%	18.0%	5.1%
2030	-1.7%	6.0%	-3.2%	12.7%	42.9%	22.5%
2035	-1.4%	7.4%	-5.4%	22.4%	46.4%	45.9%
2040	1.7%	7.5%	-1.8%	23.8%	52.7%	88.7%
2043	4.1%	7.3%	2.9%	19.2%	68.5%	92.2%

Tameside's projected population is to increase to 237,289 by 2031 (2.7%) if pre-pandemic trends continue.

Births per year in Tameside increased to a peak of 3,138 in 2010 and have fallen gradually since then. In 2021, there were 2,525 live births in Tameside. Tameside has a relatively average age profile with a median age of 40 years, compared to 40 years nationally. Tameside's child population is projected to remain stable up to 2030, whilst the population of people over 65 is expected to increase nearly 20% and the over 90 years population is projected to increase by 92.2% over 2018-2043.

Changes in population size and composition are important factors to consider in understanding population health and for planning services. In a study by Miyazawa in 2005 highlighted that with the rapid trend of population aging, some developed countries, including the UK and areas within suffer from two serious economic problems: a slowdown of growth rate and inter- and intra- generational income inequalities. The relationship between growth and inequality is at first positive and then may be negative in the process of population aging. Meaning that as with the growth of the older population intra-generational inequalities become more apparent. (Miyazawa, 2005).

In conclusion, Tameside's population has seen a steady increase over the last decade, with a slower growth rate than the national average. Although there has been a decline in the birth rates, Tameside still has a higher percentage of the population under the age of 14 compared to the national average. However, the increase in lone-parent households, especially in deprived areas, raises concerns about adverse childhood experiences and intergenerational inequalities. As the population ages, there is a projected increase in the population of people over 65 and over 90 years, which could lead to economic problems and further increases in intra-generational inequalities. These changes in population size and composition should be taken into consideration when planning for future services and addressing issues of inequality.

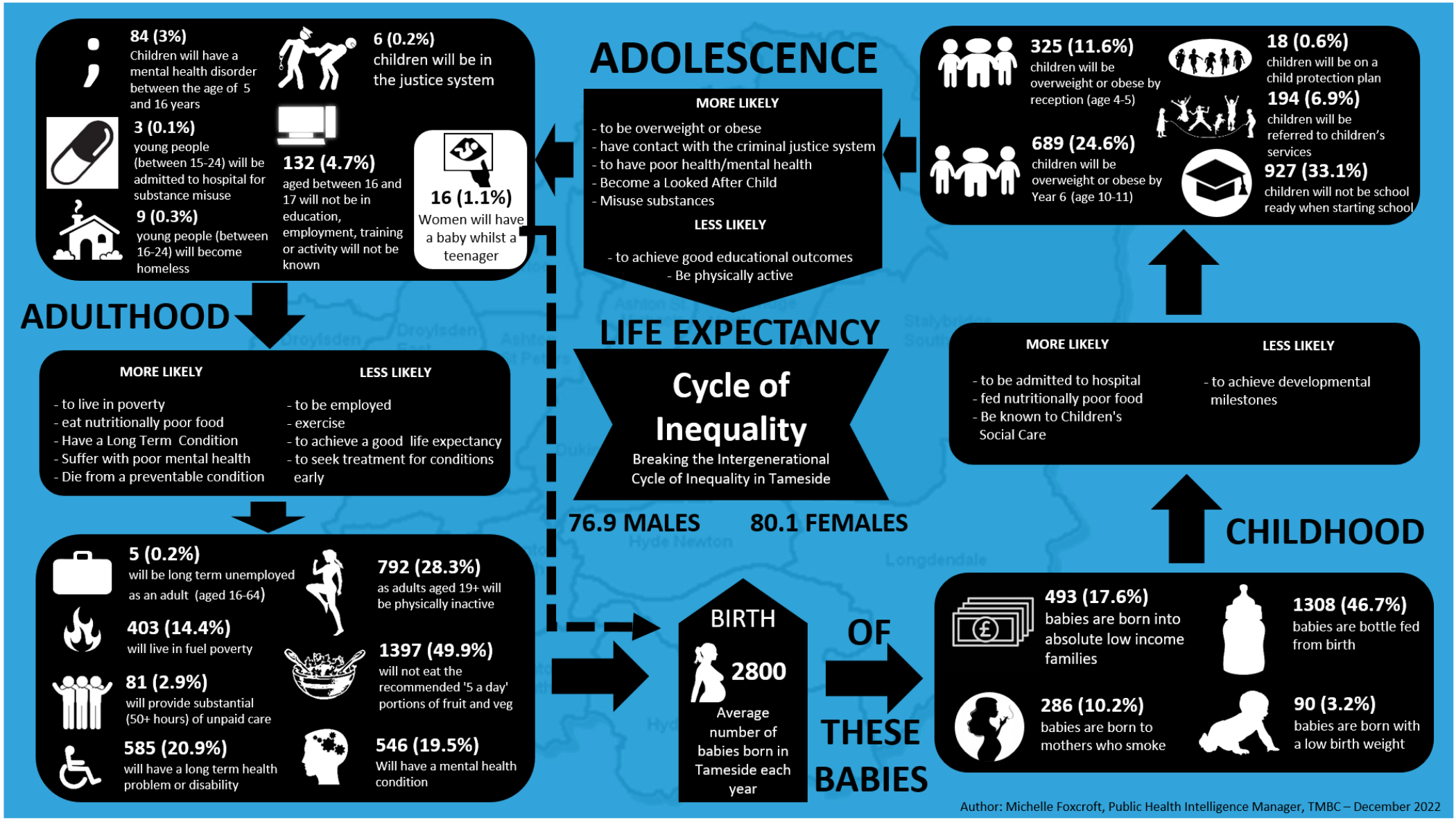
Inequality and Deprivation

What happens during pregnancy and the first few years of life influences physical, cognitive and emotional development in childhood and may affect health and wellbeing outcomes in later life. A focus on these early years is important to avoid the development of such issues and improve the health of the whole population.

This requires taking a life course approach where action to reduce health inequalities starts before birth and continues through to old age. There are overlaps and interdependencies across these life stages (for example teenage pregnancy) which highlight the need to take a life course and intergenerational approach. Intervention should be based on place and that, at its heart, improving outcomes for vulnerable children includes addressing underlying health inequalities. (OHID, 2022).

The below infographic highlights the inequality currently faced by the average number of babies born each and every year. As discussed later on in this document addressing this cycle is pivotal in order to bring about change for our borough. It also highlights the argument that Miyazawa made as outlined above.

Cycle of Intergenerational Inequality in Tameside



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Life Expectancy

Life expectancy is the average number of years a person would expect to live based on contemporary mortality rates. For a particular area and time period, it is an estimate of the average number of years a newborn baby would survive if he or she experienced the age-specific mortality rates for that area and time period throughout his or her life. Figures reflect mortality amongst those living in an area in each time period, rather than what will be experienced throughout life among those born in the area. The figures are not therefore the number of years a baby born in the area could actually expect to live, both because the mortality rates of the area are likely to change in the future and because many of those born in the area will live elsewhere for at least some part of their lives.

The figures are collected by the Office for National Statistics (ONS) from deaths from all causes and mid-year population estimates, based on data aggregated over a three-year period. It is an important summary measure, which can be used to assess population health status and highlight health inequalities.

Life expectancy (LE) at birth in Tameside remains lower for males (76.9 years) than for females (80.1 years). While this reflects the national trend, LE in Tameside continues to be statistically significantly worse than for England. The gap between Tameside and England is marginally larger for females (3 years, versus 2.5 years for males).

Female and male life expectancy in Tameside have both decreased since the last time period (2017-2019), as the beginnings of the COVID-19 impact on mortality are seen in the figures. Male Life expectancy decreased by 0.6 years and for females 0.5 years. Whilst this is also reflected in the national (England) figures, the drop in life expectancy is sharper in Tameside. The anticipation is that when 2021 figures are added in the next time period, Tameside will see a further reduction in life expectancy.

Inequalities in life expectancy for males and females in Tameside have increased since the previous time period. These inequalities are measured by the Slope Index of Inequality (SII) and at birth shows how life expectancy within Tameside varies according to deprivation. It is summarised as a single figure which represents how much longer those living in the least deprived areas of the borough (Index of Multiple Deprivation decile 10) could expect to live when compared with those living in the most deprived areas (Index of Multiple Deprivation decile 1). For Tameside males, the gap is 9.6 years and for females 9.2 years. This means that males can expect to live 9.6 years less and females 9.2 years less in our most deprived Lower Super Output Areas (LSOA), compared with the lease deprived LSOA's. Tameside is in the second worst quintile in the country for males and the worst quintile for females for inequalities in life expectancy.

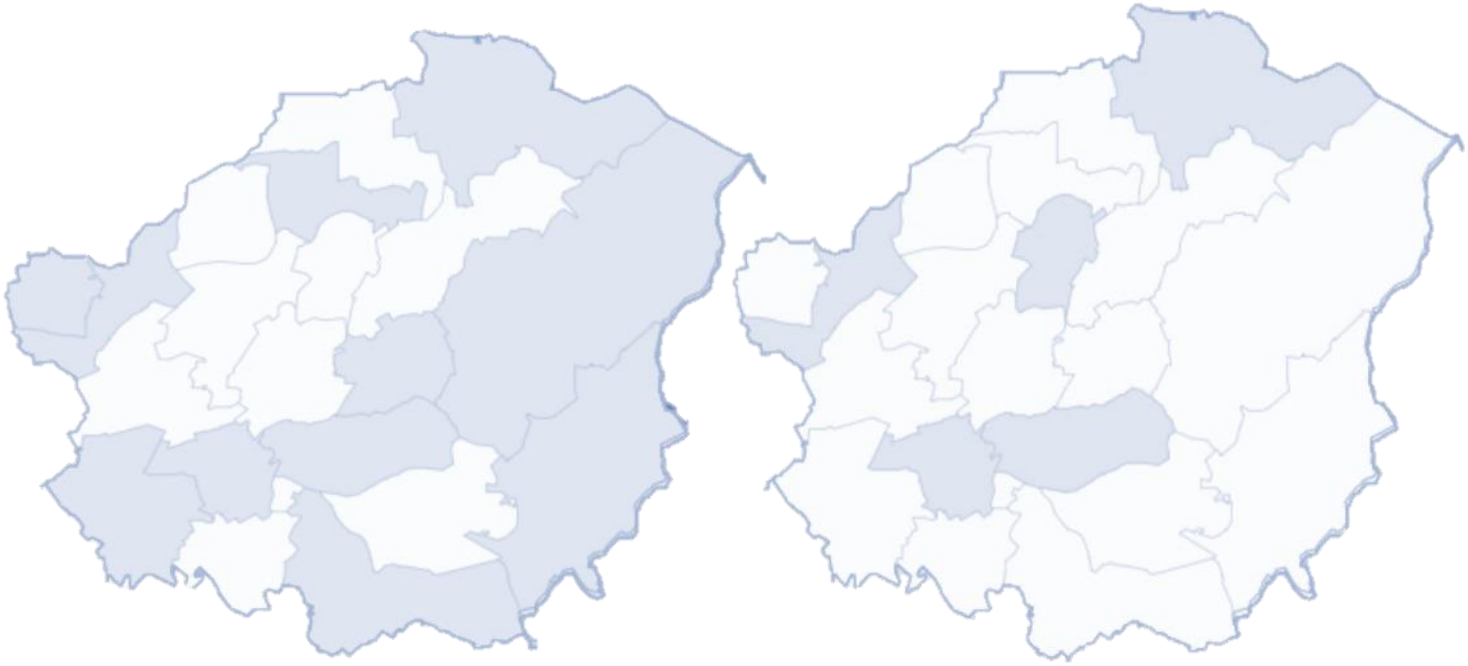
Going further for Life Expectancy for females at age 65, Tameside has the worse life expectancy in the whole country. For males, Tameside has the 10th worse life expectancy at age 65. In respect of both males and females, this contributes to the overall inequalities faced within Tameside.

Inequality in life expectancy amongst older persons and lower socioeconomic groups also has important implications for pensions (both private and state) and other related benefits. Inequality in life expectancy can have a large bearing on the length of retirement and running a risk that disadvantaged groups receive less pension, benefits and retirement from work, as they tend to die earlier and also because of ill health before death, a greater cost to the public sector system within Tameside.

Ward Level Life Expectancy

Reporting average life expectancy at a local authority level masks considerable variation at a ward level and there is significant variation in life expectancy between wards in Tameside. For females, there is a variation of 7.1 years between St Peter's ward (75.2 years) and Denton North East ward (82.3 years). For males, there is a variation of 5.2 years between St Peter's ward (74.1 years) and Stalybridge South ward (79.3 years).
Calculated using local mortality records, obtained through civil registrations data and mid-year estimates of the population, the following tables and maps display the variation for females and males by electoral ward in life expectancy. This is for the time period 2016-2020 inclusive.

Ward Level Life Expectancy Maps 2016-2020 for Males and Females



Ward Level Life Expectancy Table 2016-2020 for Males and Females

Ward Code	Ward	Male Life Expectancy	Female Life Expectancy
E05000800	Ashton Hurst	78.5	79.8
E05000801	Ashton St Michael's	76.3	81.7
E05000802	Ashton Waterloo	74.9	80.9
E05000803	Audenshaw	77.2	79.8
E05000804	Denton North East	78.4	82.3
E05000805	Denton South	75.3	80.4
E05000806	Denton West	77.9	81.3
E05000807	Droylsden East	78.8	81.5
E05000808	Droylsden West	79.1	81.4
E05000809	Dukinfield	76.4	79
E05000810	Dukinfield Stalybridge	78.5	81
E05000811	Hyde Godley	74.7	78.1
E05000812	Hyde Newton	77.6	81.7
E05000813	Hyde Werneth	78	80.9
E05000814	Longdendale	77.9	81.4
E05000815	Mossley	78.4	81.8
E05000816	St Peter's	74.1	75.2
E05000817	Stalybridge North	76	79.2
E05000818	Stalybridge South	79.3	81.2
	Difference between highest and lowest LE:	**5.2**	**7.1**

Healthy Life Expectancy

Healthy life expectancy (HLE) is an important summary measure of mortality and morbidity and is used with other indicators around life expectancy to set the context in which local authorities can identify the drivers of population health.

It is the average number of years a person would expect to live in good health based on contemporary mortality rates and prevalence of self-reported good health.

The prevalence of 'good health' is derived from responses to a survey question on general health (annual population survey). Similar to life expectancy, it is an estimate of the average number of years a newborn baby would live in good general health if he or she experienced the age-specific mortality rates and prevalence of good health for that area and time period throughout his or her life.

Figures are calculated from deaths from all causes, mid-year population estimates, and self-reported general health status, based on data aggregated over a three-year period.

As with life expectancy, the figures are not the number of years a baby born in the area could actually expect to live in good general health, both because the health prevalence and mortality rates of the area are likely to change in the future and because many of those born in the area will live elsewhere for at least some part of their lives.

HLE for males in Tameside is currently higher than that for females at 61.6 years. This is not significantly different from the figure for England (63.1 years) and is 15.3 years lower than life expectancy. This means that males in the borough can expect to live 77.9% of their lives in 'good health' or nearly a quarter of their lives in poor health.

HLE for females in Tameside is currently 58.2 years and is significantly worse than for England (63.9 years). This is 21.9 years lower than the current life expectancy and means that females in the borough can expect to live 68.3% of their lives in 'good health' or nearly a third of their lives in poor health.

Disability Free Life Expectancy

Like Healthy Life Expectancy, Disability-Free Life Expectancy (DFLE) is an important summary measure of mortality and morbidity that enables monitoring of whether life years are spent free from activity limiting long-standing illness or impairment. The estimates can be used to assess population health status and to highlight health inequalities.

DFLE is the average number of years that an individual might expect to live free from a limiting persistent illness or disability in their lifetime.

The prevalence of disability free health is derived from self-rated assessment of how health problems limit an individual's ability to carry out day-to-day activities, from the Annual Population Survey.

The DFLE estimates are a snapshot of the health status of the population during 2018 to 2020, based on self-reported health status and mortality rates for each area in that period.

DFLE for males in Tameside is currently 58.3 years, which is significantly worse than the figure for England (62.4 years). This is 18.6 years lower than the current life expectancy and means that males in the borough can expect to live 72.5% of their lives without a disability or over a quarter of their lives with a disability.

DFLE for females in Tameside is currently 54.4 years and is significantly worse than England (60.9 years). DFLE is 25.7 years lower than life expectancy and this means that females in the borough can expect to live 61.8% of their lives without a disability or over a third of their lives with a disability.

Overall, life expectancy is an important summary measure that reflects the average number of years a person would expect to live based on contemporary mortality rates. It can be used to assess population health status and highlight health inequalities. In Tameside, there are significant differences in life expectancy between males and females, as well as considerable variation at the ward level. Inequality in life expectancy amongst older persons and lower socioeconomic groups also has important implications for pensions and other related benefits. Healthy life expectancy, which is the average number of years a person would expect to live in good health based on contemporary mortality rates and prevalence of self-reported good health, is also an important summary measure of mortality and morbidity. The figures for life expectancy, healthy life

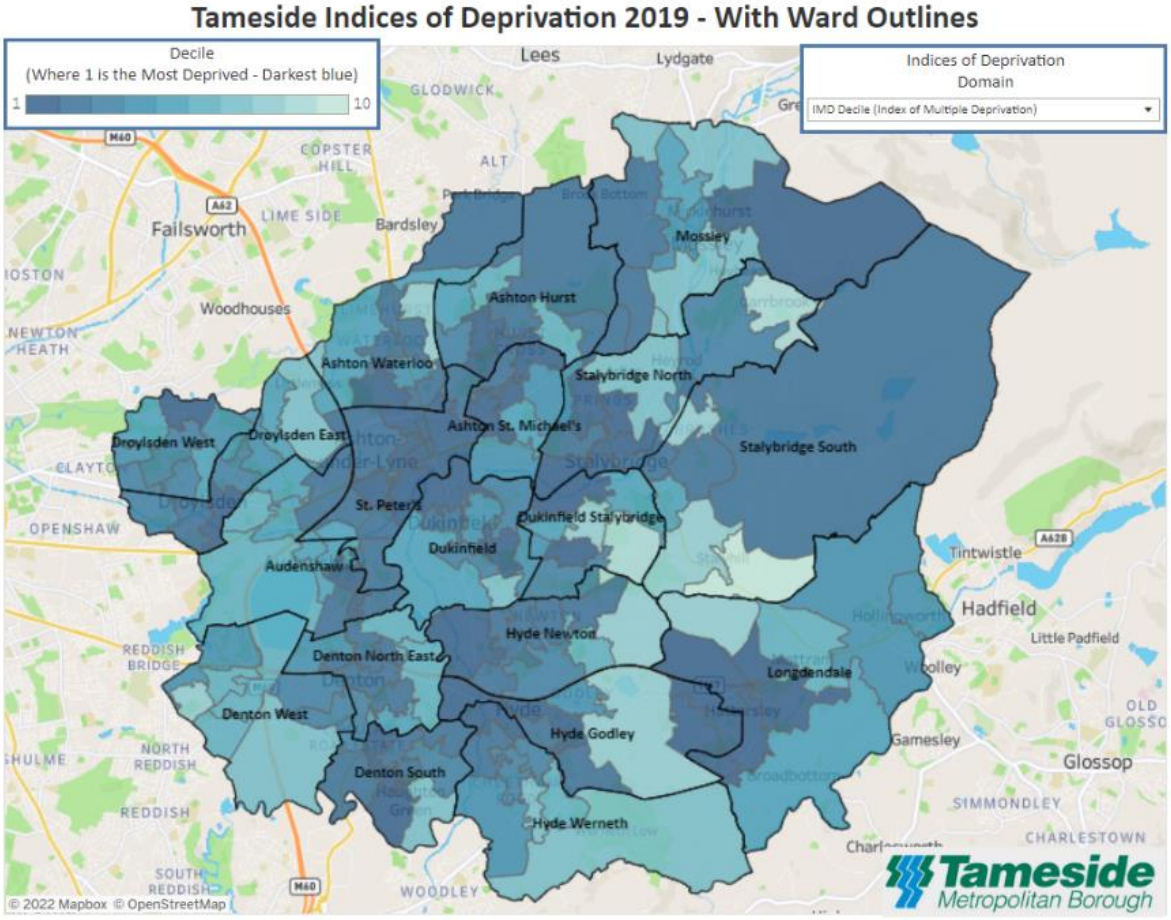
expectancy and disability free life expectancy are based on data aggregated over a three-year period and importantly should be noted; are not the actual number of years a baby born in the area could expect to live or be healthy/disability free. Instead, this is the best approximate measure and is comparable to other areas.

Indices of Deprivation

Since the 1970s the Ministry of Housing, Communities and Local Government and its predecessors have calculated local measures of deprivation in England. Deprivation refers to a lack of access to opportunities and resources required for a sufficient standard of living such as quality housing, access to health care and employment. Deprivation is not the same as poverty and although both are related, they are distinct concepts. As an example, despite having a relatively high income, a person or family may still experience deprivation because of other factors like poor housing conditions, a lack of social support systems, or limited access to opportunities and services. In relation to deprivation, the last indices of deprivation were calculated in 2019, before the COVID-19 pandemic. The English Indices of Deprivation measure relative levels of deprivation in 32,844 small areas or neighbourhoods, called Lower-layer Super Output Areas, in England. The Index of Multiple Deprivation (IMD) is the official measure of relative deprivation in England and is part of a suite of outputs that form the Indices of Deprivation (IoD). It defines deprivation to include a wide range of an individual's living conditions. People may be considered to be living in poverty if they lack the financial resources to meet their needs, whereas people can be regarded as deprived if they lack any kind of resources, not just income. The IoD 2019 is based on 39 separate indicators, organised across seven distinct domains of deprivation (Income Deprivation, Employment Deprivation, Education, Skills and Training Deprivation, Health, Deprivation and Disability, Crime, Barriers to Housing and Services and Living Environment Deprivation) which are combined and weighted to calculate the Index of Multiple Deprivation 2019. Two supplementary indices are also available; the Income Deprivation Affecting Children Index (IDACI) and the Income Deprivation Affecting Older People Index (IDAOPI).

The below map highlights the Index of Multiple Deprivation for each Lower Super Output Area (LSOA) in the borough, with electoral wards overlaid to allow for comparisons.

LSOA Map Indices of Deprivation 2019



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The Index of Multiple Deprivation 2019 combines information from the seven domains to produce an overall relative measure of deprivation. The domains are combined using the following weights: Income Deprivation (22.5%), Employment Deprivation (22.5%), Education, Skills and Training Deprivation (13.5%), Health Deprivation and Disability (13.5%), Crime (9.3%), Barriers to Housing and Services (9.3%), Living Environment Deprivation (9.3%). The weights have been derived from consideration of the academic literature on poverty and deprivation, as well as consideration of the levels of robustness of the indicators. (MHCLG, 2019). Tameside ranks overall as 23rd most deprived local authority out of 317 local authorities in England. Additionally as displayed on the map, there is widespread deprivation with the highest deprivation centred on town centres such as Ashton, Stalybridge and Hyde – with Ashton having, the most concentrated and entrenched deprivation when compared to previous Indices of Deprivation.

In conclusion, Tameside is ranked as the 23rd most deprived local authority in England, with areas such as Ashton, Stalybridge and Hyde experiencing high levels of deprivation. The Indices of Deprivation are an important tool for policymakers and researchers to understand and address deprivation in different areas, and can help to inform interventions to improve people's quality of life.

Ethnicity and Religion

Our population is increasingly diverse. According to the Census 2021, 82.32% (190,305) of Tameside residents described themselves as White British (including English, Welsh, Scottish, and Northern Irish), 85.5% (197,776) of residents identified with any White ethnic group. However nationally 74.42% of residents in England and Wales were White British, with 81.71% of residents within all White ethnic groups.

In total 17.6% of Tameside residents identify they are from an ethnic minority community. This includes White Other, Gypsy, Roma and White Irish ethnic groups. When compared to the England and Wales average Tameside is significantly lower than the average of 25.6%.

2.3% of residents were within Black ethnic groups in 2021. Across England and Wales, 4% of residents were Black, making Tameside significantly lower than the national average. Asian and Asian British residents made up 9.2% of Tameside's population on census day. The England and Wales proportion of residents from Asian groups, 9.3%, is very close to that within Tameside. Though the non-white population has increased since the last census, it remains proportionally lower than nationally.

In terms of religion, 47.8% of Tameside's residents consider themselves Christian. There is also sizeable Muslim (7.3%) community within the Borough. Just over a third of residents (38%) did not indicate any religious affiliation. There is a degree of variance in the population of each ward; these are displayed on the next page:

Ward Level Ethnic Minority Communities Population and Top 3 Religions

Ward	Percentage Persons by Ward from an Ethnic Minority Community (Any non-white British)	Percentage of Ward Christian	Percentage of Ward Muslim	Percentage of Ward No Religion
Ashton Hurst	23.7%	49.4%	9.0%	31.7%
Ashton St Michael's	31.7%	41.2%	13.8%	35.2%
Ashton Waterloo	25.0%	47.1%	11.5%	30.8%
Audenshaw	16.3%	51.1%	5.6%	37.2%
Denton North East	12.2%	51.3%	2.7%	40.4%
Denton South	11.1%	52.8%	1.9%	40.3%
Denton West	10.3%	57.6%	1.7%	35.1%
Droylsden East	18.3%	54.0%	4.2%	36.0%
Droylsden West	14.8%	54.4%	2.8%	37.5%
Dukinfield	13.3%	46.7%	3.2%	43.5%
Dukinfield Stalybridge	8.1%	52.3%	2.0%	39.8%
Hyde Godley	19.6%	40.5%	10.5%	42.6%
Hyde Newton	13.5%	44.3%	6.5%	43.5%
Hyde Werneth	24.9%	42.5%	18.7%	32.7%
Longdendale	7.8%	47.6%	1.0%	44.8%
Mossley	7.8%	50.5%	1.9%	41.6%
St Peter's	47.9%	32.6%	30.6%	28.6%
Stalybridge North	10.8%	47.6%	2.2%	43.4%
Stalybridge South	9.1%	51.7%	2.6%	38.9%
Tameside	**17.6%**	**47.8%**	**7.3%**	**38.0%**

When comparing wards, St Peter's has the highest percentage of the ward population of those who are from an ethnic minority community and are Muslim. In contrast Longendale and Mossley have the lowest ethnic minority community population and for Longendale the highest percentage of those with no religion as a proportion of the ward population.

Inequality and Ethnicity are from what past studies have shown linked. The reasons for this are multi-layered. Deprivation, low income, and poor housing are often connected with ethnic background and have all been found to be associated with an increased risk of health disparities, demonstrating that because of these pre-existing health inequalities when something like COVID-19 happened, those from an ethnic minority community background were both affected more and survivability was lower than for that of other population groups.

Overall, the Census 2021 data shows that Tameside's population is becoming increasingly diverse, with a significant proportion identifying as from an ethnic minority community. However, the non-white population remains proportionally lower than the national average. In terms of religion, Christianity is the most common affiliation, followed by Islam, with a significant proportion indicating no religious affiliation. There is considerable variance in the population of each ward, with some having a higher ethnic minority community population than others. Past studies have shown a link between ethnicity and inequality, with factors such as deprivation, low income, and poor housing being associated with increased health disparities, leading to a greater impact of health crises such as COVID-19 on the ethnic minority community population.

Disabilities

Disability has far reaching consequences for the individual and wider society; including the experience of discrimination, the support demands placed on each family concerned, and the pressures on social care ensuring that complex needs are met. In relation to discrimination 19% of disabled adults nationally experienced unfair treatment at work compared with 13% amongst the rest of the working population (Department for Business, 2008). Disability Rights UK has also highlighted the fact that a far higher proportion

of people with disabilities, and their families suffer income deprivation than average and over 50% of those with a disability lives in poverty (Disability Rights UK, 2020).

Within Tameside according to the Census 2021 20% of the overall Tameside population identified as having a disability. This is higher than the England average of 17.3%. In Tameside, this has been comparable to the last Census in 2011, although the Census categories in 2011 were slightly different. The variance on those who have a disability across the different wards within Tameside is as follows:

Ward level Disability and ill Health

Ward	Disabled Under the Equality Act	Has long-term physical or mental health condition but day-to-day activities are not limited	Not disabled under the Equality Act and No Conditions
Ashton Hurst	19.7%	6.1%	74.3%
Ashton St Michael's	19.1%	5.9%	75.1%
Ashton Waterloo	21.2%	6.4%	72.4%
Audenshaw	16.9%	6.5%	76.6%
Denton North East	20.4%	7.1%	72.5%
Denton South	23.2%	6.5%	70.2%
Denton West	18.1%	6.9%	75.0%
Droylsden East	19.3%	5.9%	74.7%
Droylsden West	20.7%	6.1%	73.3%
Dukinfield	21.5%	6.7%	71.7%
Dukinfield Stalybridge	22.2%	7.3%	70.5%
Hyde Godley	21.5%	6.4%	72.2%
Hyde Newton	19.5%	6.7%	73.8%
Hyde Werneth	17.9%	6.7%	75.5%
Longdendale	21.5%	7.5%	71.0%
Mossley	18.5%	7.9%	73.6%
St Peter's	21.1%	4.6%	74.3%
Stalybridge North	21.4%	6.9%	71.7%
Stalybridge South	16.7%	6.9%	76.5%
Tameside	**20.0%**	**6.5%**	**73.5%**

The Census 2021 has highlighted the proportion of the Tameside population living with a disability, which is higher than the national average. The data shows a variation in the prevalence of disability across different wards in Tameside. Individuals with disabilities face challenges in terms of discrimination, income deprivation and poverty, and higher demands for social care. The availability of this data can help to identify areas where targeted support and resources are needed to improve the quality of life and wellbeing of those living with a disability. It also highlights the importance of promoting greater equality and reducing discrimination for individuals with disabilities to ensure they are able to fully participate in society.

Gender Identity and Sexual Orientation

Sexual orientation and gender identity data was collected for the first time in a Census; via the Census in 2021.

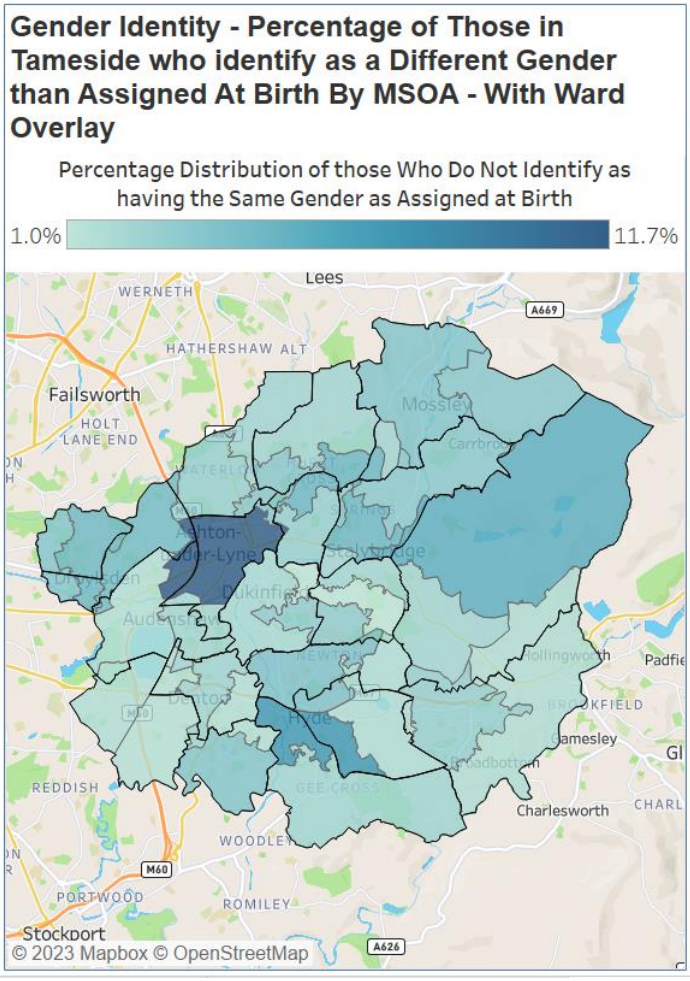
It highlights in relation to gender identity that 0.5% of people in Tameside identify as either non-binary, their gender identity different from sex registered at birth or other gender identities; with 99.5% identifying with their gender as assigned at birth. This is comparable to the England average with 0.58% of people identifying with a different gender identity than they were assigned at birth.

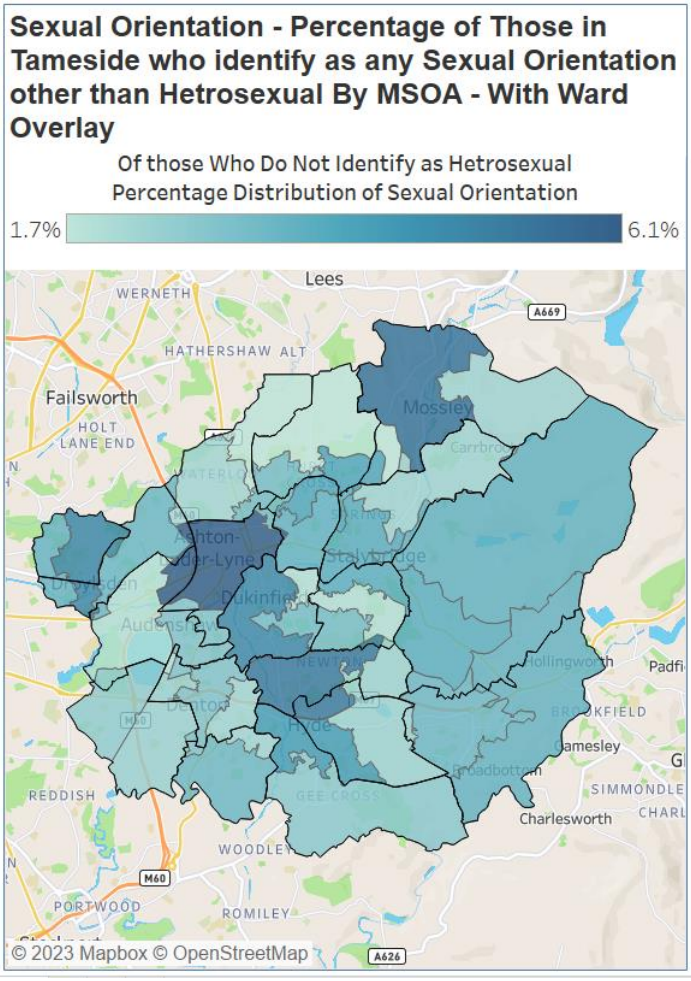
In regards to sexual orientation, 96.7% of the Tameside population identified as heterosexual with 3.3% identifying from any other sexual preference group. The second largest group in relation to sexual orientation

was the Gay/Lesbian group at 2% of the Tameside population. Similarly the England average is 96.6% identifying as heterosexual, 3.4% identifying from any other sexual preference group however slightly less identify as Gay or Lesbian 1.7% than the Tameside average.

The data for gender identity and sexual orientation is available at a Middle Super Output Area level (MSOA) the details of which can be found on the below maps.

MSOA Maps Gender Identity and Sexual Orientation





Research shows that sexual minorities (e.g., lesbian, gay, and bisexual individuals) and those with a sexual identity different from those assigned at birth, experience higher levels of discrimination, stigma, and stress and are at higher risk of some poor health outcomes and health behaviours compared to their heterosexual counterparts. In a study by Jackson et al, Compared to heterosexual women, lesbian and bisexual women were more likely to report heavy drinking. Lesbians had a higher prevalence of obesity, stroke, and functional limitation than heterosexual women. Gay men were more likely to have hypertension and heart disease. Sexual minorities were more likely than heterosexual individuals to delay seeking healthcare however; members of this group were also more likely to have received an HIV test and initiated HPV vaccination. (Chandra L. Jackson, 2016). Therefore utilising data from the Census helps to drill down into areas with higher proportions of these populations, to offer targeted information and services.

In conclusion, the Census in 2021 has provided valuable data on gender identity and sexual orientation at a local level, allowing for more targeted information and services to be provided for sexual minorities. The data shows that the majority of people in Tameside and England identify as heterosexual, with a small but significant percentage identifying as non-binary or with a gender identity different from their sex registered at birth. It is important to recognise the challenges that sexual minorities face, such as discrimination, stigma, and poor health outcomes, and to provide them with appropriate support and resources. The availability of this data for the first time can contribute to a more inclusive society and better health outcomes for all individuals.

COVID-19

In March 2020, COVID-19 became a public health priority, with cases, hospitalisations, mortality and vaccinations all being required to be monitored closely.

At the end of December 2019, Chinese public health authorities reported several cases of acute respiratory syndrome in Wuhan City, Hubei province, China (Jun She, 2020). Chinese scientists soon identified a novel coronavirus as the main causative agent (Peng Zhou, 2020). The disease is now referred to as COVID-19 (WHO, 2020), and the causative virus is called severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). It was a new strain of coronavirus that had not been previously identified in humans. On 11th March 2020, the World Health Organisation declared the outbreak of coronavirus a global pandemic (WHO, 2020).

In terms of Public Health impact, COVID-19 is an infectious virus which spreads from person to person mainly through the respiratory system after an infected person coughs, sneezes, sings, talks or breathes (Melika Lotfi, 2020). The transmission of the virus can also be impacted where people are in close contact and particularly for an extended period (BMJ, 2022). The virus causes those infected to have varying symptoms, but it leaves a proportion of those who get infected requiring medical intervention or hospital treatment. Additionally, what is now known is around 1% of those infected with the virus die (Mahase, 2020). The virus has also often been cited as the biggest public health crisis since the Spanish flu of 1918 (Gabriel Scally, 2020).

Within the United Kingdom, the first positive test for COVID-19 was confirmed by Public Health England on 31st January 2020 (Patrick J. Lillie, 2020). On the 5th March 2020, COVID-19 became a public health notifiable disease under the Health Protection (Notification) Regulations 2010 (Department of Health and Social Care, 2020) and the first case of COVID-19 was confirmed in Tameside on 6th March 2020. On the 23rd March 2020, The Prime Minister announced the first national lockdown of the county, which entailed staying at home and only leaving home for essential shopping or one form of exercise per day (UK Government, 2020). COVID-19 has been widespread in transmission, throughout the whole of the UK inclusive of Tameside since.

The Pandemic Times in Tameside

Michelle Foxcroft Population Health. May 2023

17 November 19: Chinese government records suggest that the first case of infection with COVID-19 could be traced back to a 55-year-old Hubei resident.

1 December: Symptoms of the index case, or patient zero, began on this date.

30 December: Several doctors at Wuhan Central Hospital whistle blew about the emergence of the disease.

31 January: The first two cases of coronavirus (2019-nCoV) in the United Kingdom are confirmed and Wuhan Municipal Health Commission released a briefing on its website about early signs of a pneumonia outbreak in the city.

NOV 19 - JAN 20

Start Here

28 February: The first British death from the disease is confirmed by the Japanese Health Ministry; a man quarantined on the Diamond Princess cruise ship.

29 February: The first reported case of a man in Surrey to be infected with COVID-19 whilst in the UK who had not recently travelled abroad

FEB 2020

5 March: The first death from coronavirus in the UK is confirmed as the number of cases exceeds 100, with a total of 115 having tested positive.

6 March: First case of COVID-19 in Tameside.

8 March: The first death in Greater Manchester from COVID-19 occurs.

23 March PM announces the first lockdown in the UK, ordering people to "stay at home"

25 March Coronavirus Act 2020 gets Royal Assent

26 March Lockdown measures legally come into force-

MAR 2020

6 April Lockdown extended for "at least" three weeks. Government sets out five tests that must be met before restrictions are eased

30 April PM says "we are past the peak" of the pandemic

APR 2020

10 May PM announces a conditional plan for lifting lockdown, and says that people who cannot work from home should return to the workplace but avoid public transport

MAY 2020

1 June Phased re-opening of schools in England

15 June Non-essential shops reopen in England

23 June PM says UK's "national hibernation" coming to an end – announces relaxing of restrictions and 2m social distancing rule

29 June Matt Hancock announces that the UK's first local lockdown would be applied in Leicester and parts of Leicestershire

JUNE 2020

4 July UK's first local lockdown comes into force in Leicester and parts of Leicestershire. More restrictions are eased in England, including reopening of pubs, restaurants, hairdressers.

18 July Local authorities in England gain additional powers to enforce social distancing

JULY 2020

3 August Eat Out to Help Out scheme, offering a 50% discount on meals up to £10 per person, begins in the UK

14 August Lockdown restrictions eased further, including reopening indoor theatres, bowling alleys and soft play

AUG 2020

14 September 'Rule of six' – indoor and outdoor social gatherings above six banned in England

22 September PM announces new restrictions in England, including a return to working from home and 10pm curfew for hospitality sector

30 September PM says UK at a "critical moment" in the crisis and would "not hesitate" to impose further restrictions if needed

SEPT 2020

14 October A new three-tier system of Covid-19 restrictions starts in England

31 October PM announces a second lockdown in England to prevent a "medical and moral disaster" for the NHS

OCT 2020

5 November Second national lockdown comes into force in England

24 November PM announces up to three households will be able to meet up during a five-day Christmas period of 23 to 27 December

NOV 2020

2 December Second lockdown ends after four weeks and England returns to a stricter three-tier system of restrictions

8 December Margaret Keenan became the first person in the world (outside trials) to receive her first dose of two of the Pfizer–BioNTech COVID-19 vaccine.

15 December PM says Christmas rules will still be relaxed but urges the public to keep celebrations "short" and "small"

19 December PM announces tougher restrictions for London and South East England, with a new Tier 4 'Stay at Home' alert level. Christmas mixing rules tightened.

21 December Tier 4 restrictions come into force in London and South East England

26 December More areas of England enter Tier 4 restrictions

DEC 2020

4 January PM says children should return to school after the Christmas break, but warns restrictions in England will get tougher. Target set to get all top four priority groups vaccinated by mid February.

6 January England enters third national lockdown

JAN 2021

14 February 15 million people in top four priority groups have been offered and most received, their first dose of a vaccine.

15 February Hotel quarantine for travellers arriving in England from 33 high-risk countries begins

22 February PM publishes a roadmap for lifting the lockdown

FEB 2021

8 March: Step 1 Schools in England reopen for primary and secondary school students. Recreation in an outdoor public spaces will be allowed between two people. 'Stay at home' order remains in place.

29 March: Step 1 Outdoor gatherings of either six people or two households will be allowed, including in private gardens. Outdoor sports facilities also reopen. 'Stay at home' order ends but people encouraged to stay local.

MAR 2021

14 June: PM confirms Step 4 of the roadmap will be delayed by four weeks, as the government accelerates the vaccination programme. Restrictions on weddings and funerals abolished.

18 June All adults offered first does of vaccine.

19 July: Step 4 Most legal limits on social contact removed in England, and the final closed sectors of the economy reopened (e.g. nightclubs)

14 September PM unveils England's winter plan for Covid – 'Plan B' to be used if the NHS is coming under "unsustainable pressure", and includes measures such as face masks.

September First booster doses of vaccines rolled out vulnerable groups 6 months after the last vaccine.

SUMMER 2021

2 April: Step 2 Non-essential retail, hairdressers, public buildings (e.g. libraries and museums) reopen. Outdoor venues, including pubs and restaurants, zoos and theme parks also open, as well as indoor leisure (e.g. gyms). Self-contained holiday accommodation opens. Wider social contact rules continue to apply in all settings – no indoor mixing between different households allowed.

17 May: Step 3 Limit of 30 people allowed to mix outdoors. 'Rule of six' or two households allowed for indoor social gatherings. Indoor venues will reopen, including pubs, restaurants, cinemas. Up to 10,000 spectators can attend the very largest outdoor-seated venues like football stadiums

SPRING 2021

1 April The highest recorded number of cases since records began in April 2020.

13 April Party gate exposure.

28 June Public inquiry begins into the UK's handling of the pandemic. This is still ongoing as of May 2023.

SPRING 2022

8 December PM announces a move to 'Plan B' measures in England following the spread of the Omicron variant. 10 December Face masks become compulsory in most public indoor venues under Plan B.

15 December NHS Covid Pass becomes mandatory in specific settings, such as nightclubs under Plan B.

15 February Vaccines offered to all children aged over 5.

AUTUMN/ WINTER 2021/2022

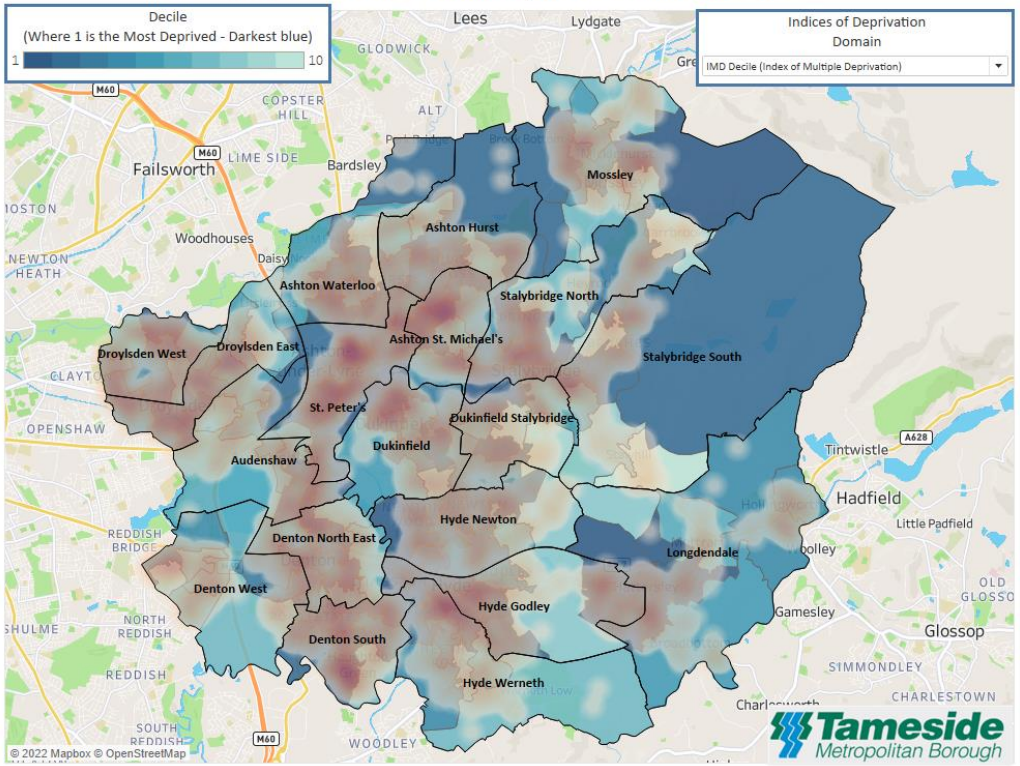
Tameside Metropolitan Borough

Cases of COVID-19

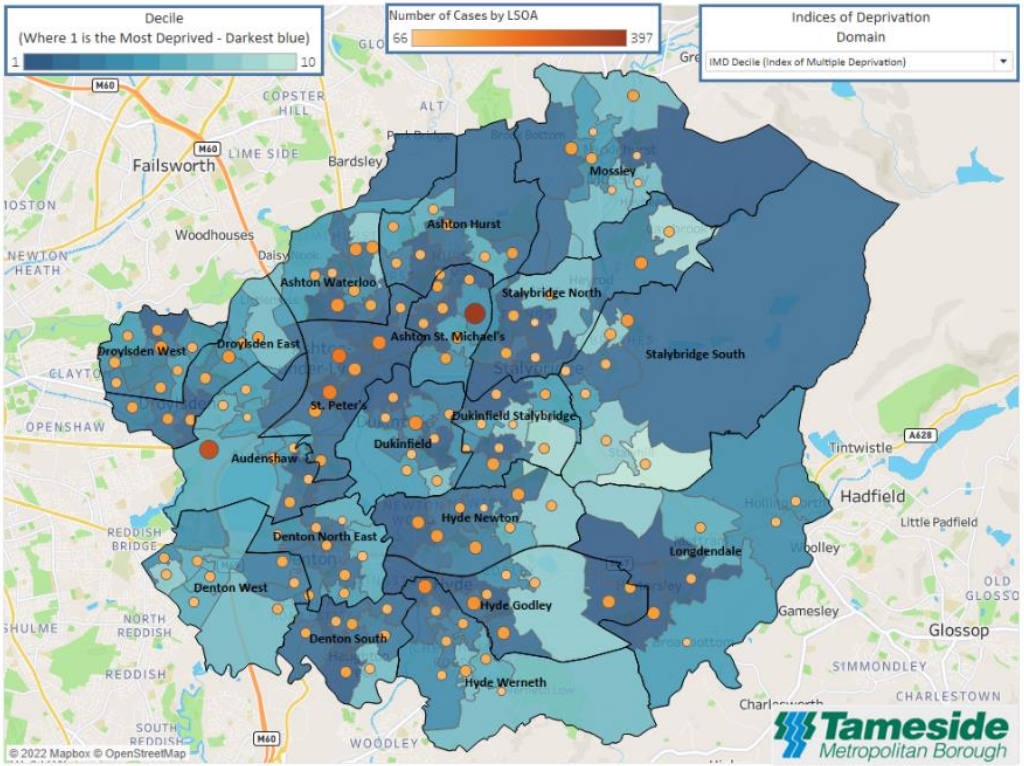
From the initial case on 6th March 2020, COVID-19 has become widespread in the area, reflecting the national trend. The impacts of COVID-19 however have not been felt equally. During the pandemic, there has been a spotlight on the impact of health inequalities. The greatest impacts have fallen on those who are the least privileged. COVID-19 has replicated and exacerbated existing health inequalities. Further research is still ongoing to understand the impacts of Covid-19, but we know that risk factors such as ethnicity, deprivation, occupation, disability and ill health relate to prevalence. Below are maps which highlight the prevalence of COVID-19 cases in Tameside, from the initial case up until free testing in April 2022 ceased (as cases became both less reported and less tested for after this time).The amount of cases is fairly widespread as in the second point map. However analysing the maps via the density map, this highlights that the concentration of cases was far higher in the towns of Tameside and in particular when mapped against the Indices of Deprivation, in the more deprived areas of Tameside.

Maps Displaying the Cases of COVID-19 – 06/03/2020 to 31/03/2022

Tameside COVID-19 Density of Cases and IMD 2019



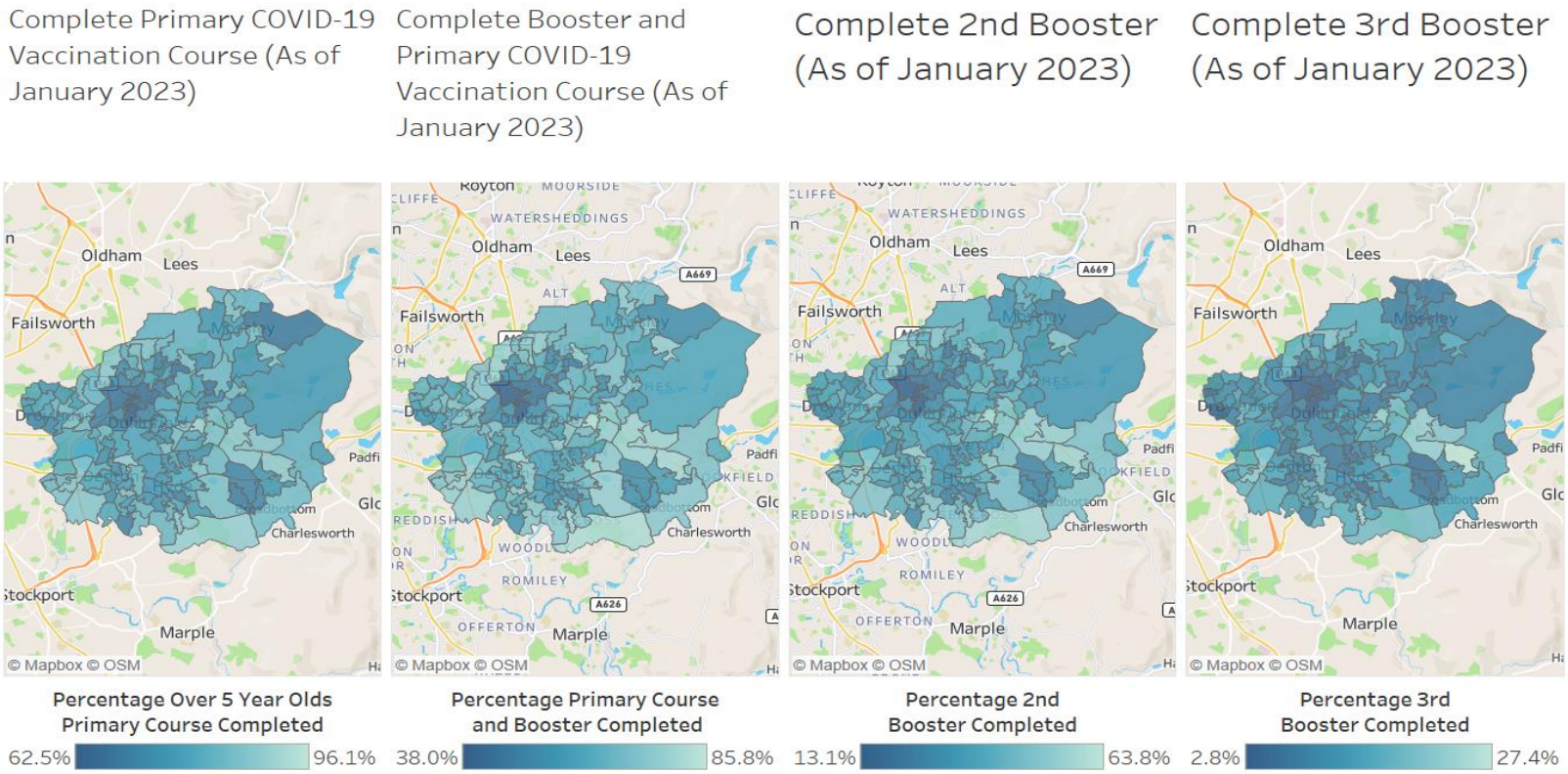
Tameside COVID-19 Lower Super Output Area of Collective Cases and IMD 2019



Vaccinations against COVID-19

A review of research into vaccine uptake in the UK by the Local Government Association found the following groups are on average less likely to get a Covid vaccination than others: ethnic minority communities, economic deprivation, those who are Mentally ill and those with learning disabilities, Women, Young people, those with English as a second language, transient and migrant workers, homeless populations, people not registered with a GP, those living in less accessible geographical areas, traveller communities, key workers, semi-skilled and unskilled workers and unemployed people, orthodox religious groups, Pregnant women and parents and people living with children. (Local Government Association, 2021). The below maps highlight the vaccine uptake in Tameside by LSOA.

COVID-19 Vaccination Uptake Maps



The case by the Local Government Association regarding uptake, has been broadly the reflected within Tameside, with the areas with higher concentrations of the above listed populations, having lower uptake, and less likely to finish a vaccination course or receive boosters. Work has been carried out with local PCN's

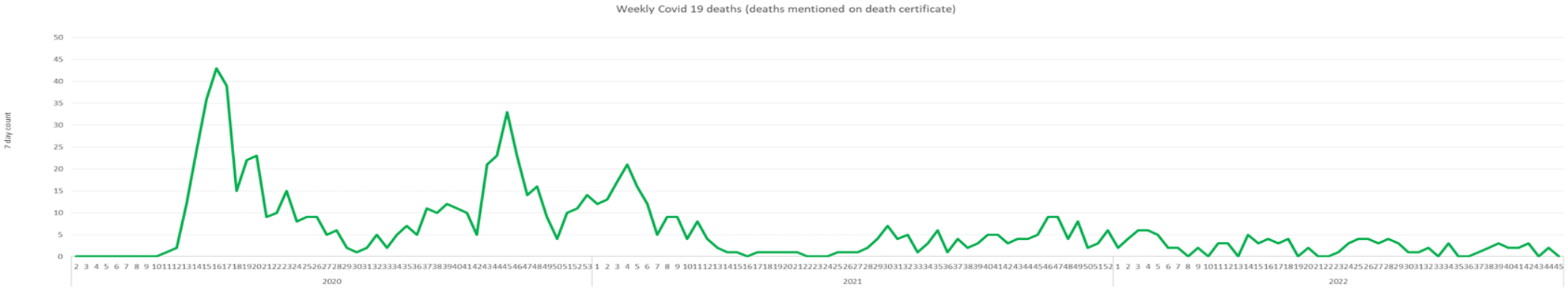
to try to address this. Broadly speaking this also correlates to the experience of the flu vaccine uptake, and as we are in the living with COVID-19 phase of the pandemic, COVID monitoring moving forward is aligning to the flu vaccination programme.

COVID-19 and Mortality

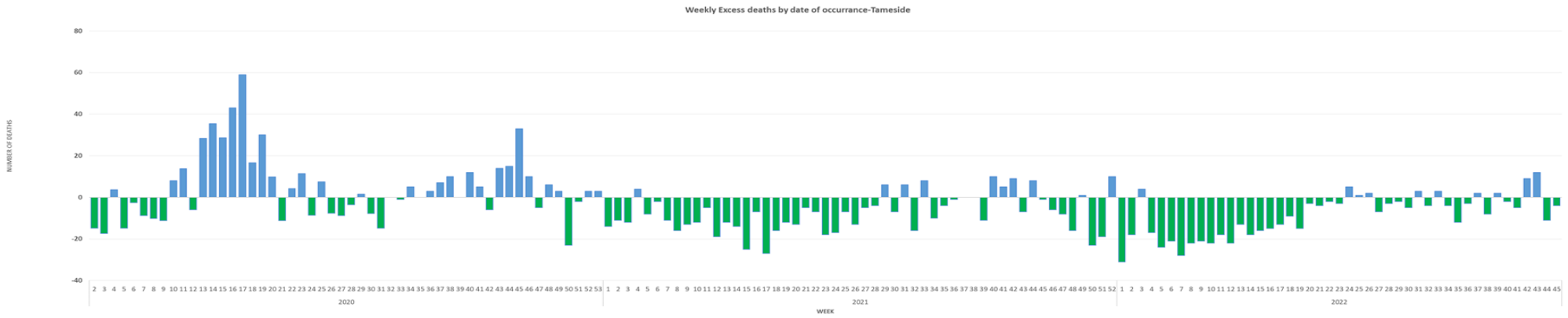
In a review of papers by the (Lancet, Public Health - Victoria J McGowan, Clare Bambra, 2022), it was found that COVID-19 mortality rates were higher in areas of socioeconomic disadvantage than in affluent areas. The unequal nature of the pandemic has resulted from entrenched inequalities in chronic disease burden with those from more deprived areas. Because of this when COVID-19 came, it hit those who are more deprived harder and in turn more people from deprived backgrounds died as a result.

In total to the end of 2022 there were 1027 deaths registered with COVID-19 on the death certificate. Below is a graph highlighting the trend over the pandemic of deaths with COVID-19 listed on any line of the death certificate.

COVID-19 Deaths Recorded on Death Certificate Timeline 2020-2022



Excess Deaths 2020-2022



As seen on the first graph, there is peaks around the height of lockdown and school returning and a reduction in the amount of deaths once the COVID-19 vaccination rollout began.

However, over the course of the pandemic, it is not just COVID-19 deaths that have been under the spotlight, it is the amount of deaths in total. When compared to the average figures for deaths in Tameside between 2015 and 2019, Tameside has experienced a large amount of excess deaths. Excess deaths in this respect are any amount of deaths above the average amount of expected deaths. The below graph illustrates the excess death pattern throughout the pandemic.

Although the trend of excess deaths follows the pattern of COVID-19 deaths, the excess deaths are not all directly due to COVID-19 illness. The COVID-19 pandemic has also contributed indirectly to deaths via illnesses such as:

- People who did not seek treatment for medical emergencies such as strokes or heart attacks.
- Planned treatment and screening being postponed or cancelled due to the pandemic.
- Staff shortages in the NHS, owing to the pandemic and other political factors.
- Waiting lists for treatment increasing because of the waiting lists increasing during the COVID-19 pandemic.
- Mental health problems deteriorating and suicides because of this.
- Cardiovascular problems, obesity problems and diet problems from lack of physical activity and economic instability.
- The impact on health from increased unemployment and reduced living standards.

The trends however of excess deaths do fall in line with those of the England average, however especially during the first wave of the pandemic, pre-vaccinations, excess deaths hit Tameside hard, and especially affected deprived groups and individuals with multiple co-morbidities. Additionally as outlined above in respect of ethnicity and other inequality groups, COVID-19 cases and deaths affected these groups more than others.

In conclusion, COVID-19 has been a significant global public health crisis since its emergence in late 2019. The virus spreads easily through respiratory transmission and has varying symptoms, with a proportion of those infected requiring medical intervention or hospitalisation, and a mortality rate of around 1%. Health inequalities have been replicated and exacerbated by COVID-19, with those who are least privileged and living in more deprived areas being hit the hardest. Vaccinations against COVID-19 have been rolled out in Tameside, but uptake has been lower in certain groups, including those from more deprived backgrounds. COVID-19 mortality rates have been higher in areas of socioeconomic disadvantage than in affluent areas, reflecting existing health inequalities. Moving forward, it is essential that we continue to monitor and address the impact of COVID-19, particularly in relation to health inequalities, although with the ceasing of free testing and data reporting becoming minimal, new techniques are required to monitor this – with the main source being vaccination uptake.

Life in Tameside

Lifestyle Factors

Substance misuse

Excessive alcohol use is a significant public health issue in Tameside and is closely related to multiple conditions, such as liver disease, cancer, and heart disease diseases, and ultimately premature mortality rates. Alcohol and premature mortality have a complex relationship that is largely influenced by the amount and frequency of alcohol consumption, a person's age and health status, and the presence of additional risk factors like smoking and obesity (Office for Health Improvement and Disparities, 2023). Studies have shown that even moderate alcohol use can increase the risk of developing certain diseases like liver disease and some types of cancer including liver, bowel and breast cancers. However, higher consumption levels significantly increase the risk (Oxford University Population Health, 2022). Alcohol misuse is estimated to cost the NHS about £3.5 billion per year and the impact on the society is even higher at £21 billion annually (Home Office, 2012). The government set out the alcohol strategy to reduce the harmful use of alcohol and provide an evidence base to commission local services.

Additionally the misuse of drugs in Tameside have been linked to a range of negative impacts for individuals, families and communities, including premature death, a reduced quality of life, conditions related to the drug misuse and increased social issues, including homelessness, violence and Domestic Abuse, which require interventions from state and community-level service provision. In 2019, the UK Health and Social Care Committee recommended a radical change in UK drugs policy moving from a criminal justice to a health approach, where responsibility for drugs policy rests with the Department of Health and Social Care and not the Home Office. An estimation by (Office for Health Improvement and Disparities, 2023) shows that drug treatment provides a return on investment of £4 for every £1 invested, which can increase to £21 over 10 years.

The data presented below highlights evidence-based treatment activities at a local level.

Fingertips Substance Misuse Treatment Indicators

Indicator	Period	Tameside			Region	England	England		
		Recent Trend	Count	Value	Value	Value	Worst	Range	Best
Hospital admissions due to substance misuse (15-24 years)	2018/19 - 20/21	–	70	95.0	106.0	81.2	229.4		16.9
Adults with substance misuse treatment need who successfully engage in community-based structured treatment following release from prison New data	2021/22	↑	41	56.2%	43.9%	37.4%	12.0%		91.5%
Smoking prevalence in adults (18+) admitted to treatment for substance misuse (NDTMS) - all opiates	2019/20	–	161	80.9%	72.4%	70.2%	90.9%		41.4%
Smoking prevalence in adults (18+) admitted to treatment for substance misuse (NDTMS) - non-opiates	2019/20	–	78	76.5%	62.5%	62.0%	91.2%		29.0%
Smoking prevalence in adults (18+) admitted to treatment for substance misuse (NDTMS) - alcohol	2019/20	–	139	55.8%	46.1%	43.9%	63.6%		17.6%
Smoking prevalence in adults (18+) admitted to treatment for substance misuse (NDTMS) - alcohol & non-opiates	2019/20	–	106	82.2%	69.0%	64.6%	92.4%		37.1%

This highlights that Tameside has significantly worse outcomes for those in treatment services when compared to the national average. Further work is required to explore this in more depth, see recommendations.

Obesity and Weight Management

In regards to weight management post COVID-19 in Tameside it was estimated that in 2021/22 around one in four (24.6%) of reception aged children and over one third (39.2%) of children in year six were overweight or obese. The trend for both has been staying the same when compared to the last data point and for Reception age children is significantly worse than the England average. Also in 2021/22, around 1% of reception age children and 1.4% of year 6 children were underweight. Although this is not significantly different from the England average, it is alongside obesity a good indicator around nutrition, and can be indicative of food poverty.

Taken from a committee paper presented to parliament Malnutrition (not including obesity) has, surprisingly for an economically developed country such as the UK, become increasingly prevalent. According to Purdam et al (2015) three million people in the UK are at risk of malnutrition with £13bn a year spent on diseases related to it. Falling wages and rising house prices since the 2008 financial crisis and subsequent COVID-19 pandemic have been contributing factors affecting access to healthy food for many families. (Visformatics, 2019).

The below table taken from the Office for Health improvement and Disparities fingertips tool, highlights the above points. (Office for Health Improvement and Disparities, 2023).

Fingertips Weight Management Indicators

Indicator	Period	Tameside			Region	England	England		England
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Reception: Prevalence of underweight New data	2021/22	➡	25	1.0%	1.1%	1.2%	4.6%		0.3%
Reception: Prevalence of healthy weight New data	2021/22	➡	1,800	74.4%	75.6%	76.5%	69.9%		86.2%
Reception: Prevalence of overweight (including obesity) New data	2021/22	➡	595	24.6%	23.3%	22.3%	28.9%		12.9%
Reception: Prevalence of overweight New data	2021/22	➡	310	12.8%	12.7%	12.1%	7.0%		16.5%
Reception: Prevalence of obesity (including severe obesity) New data	2021/22	➡	280	11.6%	10.6%	10.1%	14.9%		3.9%
Reception: Prevalence of severe obesity New data	2021/22	➡	80	3.3%	3.0%	2.9%	5.8%		0.9%
Year 6: Prevalence of underweight New data	2021/22	➡	35	1.4%	1.3%	1.5%	4.4%		0.6%
Year 6: Prevalence of healthy weight New data	2021/22	➡	1,500	59.4%	59.6%	60.8%	49.0%		78.7%
Year 6: Prevalence of overweight (including obesity) New data	2021/22	➡	990	39.2%	39.0%	37.8%	49.1%		16.9%
Year 6: Prevalence of overweight New data	2021/22	➡	370	14.7%	14.6%	14.3%	9.3%		17.4%
Year 6: Prevalence of obesity (including severe obesity) New data	2021/22	➡	620	24.6%	24.4%	23.4%	34.0%		7.7%
Year 6: Prevalence of severe obesity New data	2021/22	➡	150	5.9%	6.1%	5.8%	10.4%		1.1%
C15 - Proportion of the population meeting the recommended '5-a-day' on a 'usual day' (adults)	2019/20	–	-	50.1%	51.2%	55.4%	41.4%		65.8%
C16 - Percentage of adults (aged 18+) classified as overweight or obese	2020/21	–	-	70.3%	65.9%	63.5%	76.3%		44.0%

When looking at the adult population, in 2020/21 over two thirds (70.3%) of adults are overweight or obese. This is significantly worse than the national estimate of 63.5% and has been on a worsening trend albeit a slight decrease in the last data point from 2019/20. In respect of eating the recommended fruit and vegetables, 50.1% of the adult population are meeting the recommended '5 a day' on a usual day, making this significantly worse than the England average. In addition, deprivation plays a factor, with those coming from a more deprived background more likely to be overweight/obese and not eat the recommended five a day.

Smoking

Smoking is a major cause of preventable illnesses and premature deaths in Tameside and the wider UK population. Smoking can lead to a wide range of diseases including cancer, chronic obstructive pulmonary disease (COPD), heart disease, stroke to name a few, but there are many other serious conditions it contributes to. In addition to impacts on individuals, smoking has significant economic implications, for not only the national and local economy but for households all over Tameside. The cost of smoking each year to society in the UK is estimated to be £17.04 billion (ASH, 2023).

Smoking has a significant impact on the inequalities as smoking rates in the UK are higher in deprived population groups, who in turn are already more likely to experience poor health outcomes. One particular group that has been monitored consistently are blue-collar workers in respect of smoking. The term blue-collar worker refers to individuals who engage in hard manual labour, typically in the agriculture, manufacturing, construction, mining, or maintenance sectors. Most of these people historically wore blue-collared shirts when they worked. Some of the most common blue-collar jobs include welders, mechanics, electricians, and construction workers. Most of these workers hold both apprenticeship and/or college level qualifications and the vast majority do not have university education. Because of this historically and the fact many of these jobs are conducted outdoors, there was an increased smoking prevalence amongst the blue-collar worker population. In Tameside 27.5% or just over a quarter of all adults in blue-collar professions smoke. Although this is not significantly different from the England average, this still equates to around 8,305 people, so almost a quarter of adults who smoke in Tameside.

Below are the indicators taken from (Office for Health Improvement and Disparities, 2023) fingertips tool in direct relation to smoking prevalence.

Fingertips Smoking Indicators

Indicator	Period	Tameside			Region	England	England		
		Recent Trend	Count	Value	Value	Value	Worst	Range	Best
Smoking prevalence									
Smoking Prevalence in adults (18+) - current smokers (APS) New data	2021	–	-	19.2%	14.4%	13.0%	22.0%		6.6%
Odds of current smoking (self-reported) among adults aged 18-64 with a routine and manual occupation (APS) New data	2020	–	-	1.73	2.07	2.22	8.38		0.39
Smoking prevalence in priority populations									
Smoking prevalence in adults in routine and manual occupations (18-64) - current smokers (APS) New data	2020	–	-	27.5%	25.1%	24.5%	42.1%		5.3%
Smoking status at time of delivery	2021/22	↓	227	10.2%	10.6%	9.1%	21.1%		3.1%
Smoking attributable mortality (new method)	2017 - 19	–	1,239	351.0	247.5	202.2	419.7		103.4
Smoking attributable hospital admissions (new method). This indicator uses new set of attributable fractions, and so differ from that originally published.	2019/20	↓	2,340	1,862	1,540	1,398	3,071		516

It has been estimated that in 2021 just under one in five (19.2%) of adults were smokers in Tameside. This is higher than the national average of 13.9% and in respect of Tameside equates to an estimated 34,535 adults who smoke.

Physical Activity in Tameside

Regular physical activity provides a range of physical and mental health benefits. These include reducing the risk of disease (primary prevention), managing existing conditions (secondary prevention), and developing and maintaining physical and mental wellbeing. The UK Chief Medical Officers' guidelines provide recommendations on the frequency, intensity, duration and types of physical activity and the recommendations should be consulted regularly to check for updates. In Tameside the below indicators give an indication of physical activity in the borough.

Fingertips Physical Activity Indicators

Indicator	Period	Tameside		Region	England	England		
		Count	Value	Value	Value	Worst	Range	Best
Percentage of physically active adults	2020/21	-	59.8%	64.5%	65.9%	48.8%		78.4%
Percentage of physically inactive adults	2020/21	-	28.3%	24.9%	23.4%	38.1%		11.6%
Percentage of physically active children and young people	2020/21	-	*	44.0%	44.6%	-	*Insufficient number of values for a spine chart*	-
Percentage of adults walking for travel at least three days per week	2019/20	-	12.7%	13.4%	15.1%	6.5%		33.4%
Percentage of adults cycling for travel at least three days per week	2019/20	-	1.0%	1.8%	2.3%	0.0%		20.9%
Percentage physically active for at least one hour per day seven days a week at age 15	2014/15	-	14.3%	13.2%	13.9%	-	*Insufficient number of values for a spine chart*	-
Percentage with a mean daily sedentary time in the last week over 7 hours per day at age 15	2014/15	-	75.8%	71.2%	70.1%	-	*Insufficient number of values for a spine chart*	-
Utilisation of outdoor space for exercise/health reasons	Mar 2015 - Feb 2016	-	14.5%	17.5%	17.9%	-	*Insufficient number of values for a spine chart*	-

The data above highlights 59.8% of adults are physically active in Tameside. This is worse than the national estimate of 65.9%. Additionally, while the data is only available at a regional level, just under half (48.5%) of children in the North West get their recommended amount of exercise. There is also a lower than average use of outdoor space for exercise in the borough. Work within the Population Health team has been ongoing to increase physical activity take up in the borough. This includes everything from bike sales to Bollywood dance taster sessions for children.

In conclusion, substance misuse, obesity and weight management, and smoking are significant public health concerns in Tameside. Alcohol misuse and drug addiction are linked to multiple health conditions, premature mortality rates, and significant financial costs for the NHS and society. Obesity, malnutrition, and inadequate nutrition are prevalent issues among both children and adults in Tameside, with deprivation playing a significant role. Smoking is a major cause of preventable illnesses and premature deaths in Tameside, with a significant impact on health inequalities. Addressing these issues requires a multifaceted approach involving government policies, local service provision, and community-level interventions. By taking concerted action, it is possible to improve public health outcomes and reduce the financial burden on healthcare systems and society as a whole in Tameside.

Education and Development

Improving Tameside's educational provision and attainment is essential to driving up the skill levels in Tameside's future adult and working population. Good quality provision helps to increase attainment, which provides choice for Tameside's young people in the type and level of employment they can access. Ultimately, it also benefits Tameside as those children who go on to live within the borough and have good, stable employment, increase the prosperity of Tameside as a whole.

Fingertips Education and Development Indicators - Children

Indicator	Period	Tameside			Region	England	England		
		Recent Trend	Count	Value	Value	Value	Worst	Range	Best
Proportion of New Birth Visits (NBVs) completed within 14 days	2021/22	↑	2,305	91.9%	85.7%	82.6%	9.5%		99.0%
Proportion of infants receiving a 6 to 8 week review	2021/22	→	2,234	89.0%	85.0%	81.5%	5.6%		99.8%
Proportion of children receiving a 12-month review	2021/22	↓	2,319	92.2%	85.8%	81.9%	22.2%		99.1%
Proportion of children who received a 2-2½ year review	2021/22	→	2,548	90.8%	79.9%	74.0%	6.9%		98.8%
Proportion of children aged 2-2½yrs receiving ASQ-3 as part of the Healthy Child Programme or integrated review	2021/22	→	2,391	92.3%	93.5%	90.3%	31.5%		100%
Child development: percentage of children achieving a good level of development at 2 to 2½ years ⚠	2021/22	→	1,948	81.5%	79.2%	81.2%	43.5%		95.3%
Child development: percentage of children achieving the expected level in communication skills at 2 to 2½ years ⚠	2021/22	→	1,973	82.5%	86.0%	86.5%	52.5%		95.6%
Child development: percentage of children achieving the expected level in gross motor skills at 2-2½ years ⚠	2021/22	↑	2,297	96.1%	94.4%	93.5%	62.9%		98.8%
Child development: percentage of children achieving the expected level in fine motor skills at 2-2½ years ⚠	2021/22	↑	2,280	95.4%	93.4%	93.3%	59.3%		99.5%
Child development: percentage of children achieving the expected level in problem solving skills at 2-2½ years ⚠	2021/22	→	2,272	95.0%	93.4%	92.7%	66.2%		99.1%
Child development: percentage of children achieving the expected level in personal social skills at 2 to 2½ years ⚠	2021/22	→	2,209	92.4%	91.9%	91.2%	60.8%		100%
School readiness: percentage of children achieving a good level of development at the end of Reception	2021/22	–	-	60.1%	61.7%	65.2%	53.1%		74.4%
School readiness: percentage of children achieving at least the expected level in communication and language skills at the end of Reception	2021/22	–	-	76.2%	76.5%	79.5%	68.0%		90.0%
School readiness: percentage of children achieving at least the expected level of development in communication, language and literacy skills at the end of Reception	2021/22	–	-	62.5%	63.6%	67.1%	54.5%		76.5%
Persistent absentees - Primary school New data	2020/21	–	1,200	6.5%	8.8%	8.8%	13.7%		5.2%
Persistent absentees - Secondary school New data	2020/21	–	1,947	13.5%	15.7%	14.8%	26.0%		7.8%
Key stage 2 pupils meeting the expected standard in reading, writing and maths	2019/20	–	1,878	63.4%	64.6%	65.3%	53.6%		81.0%
Key stage 1 pupils meeting the expected standard in reading New data	2021/22	–	1,899	64.0%	65.0%	67.0%	58.0%		77.0%
Key stage 1 pupils meeting the expected standard in writing New data	2021/22	–	1,617	55.0%	55.0%	58.0%	48.0%		71.0%
Key stage 1 pupils meeting the expected standard in maths New data	2021/22	–	1,940	66.0%	66.0%	68.0%	59.0%		76.0%
Key stage 1 pupils meeting the expected standard in science New data	2021/22	–	2,189	74.0%	75.0%	77.0%	64.0%		86.0%
Average Attainment 8 score New data	2021/22	–	123,275	45.6	47.1	48.7	39.2		61.3
Average Attainment 8 score of children in care	2021	–	1,229	21.9	24.1	23.2	14.2		38.3
First time entrants to the youth justice system	2021	↓	33	151.6	133.2	146.9	446.9		56.3
16 to 17 year olds not in education, employment or training (NEET) or whose activity is not known	2021	→	401	8.1%	4.9%	4.7%	14.7%		1.4%

Developmental visits first begin for children within 14 days of their birth from a health visitor. This monitoring is important, as the first 1000 days are the most vital in child development. (House of Commons, Health and Social Care Committee, 2019). For health visiting, all metrics are significantly better than the England average with the exception of communication on the ASQ3 (the 2-2 ½ year child check), where it is significantly worse. Recommendation is for work in this area owing to communication skills being vital in this stage of development and with the Children's Hubs being established within Tameside, part of the programme may need to reflect the need for this.

The next stage of development is the proportion of children achieving a Good Level of Development (GLD) in Tameside, which is conducted during the first term after a child's fifth birthday. In Tameside, this is 61% in 2021/22 and is significantly worse than the England average ranking as 11th worse in the country. The 2021/22 GLD result is the first full year result post COVID-19 and could be an indication of COVID-19 impacting on child development and Tameside not recovering this as quickly as other areas. Girls outperform boys in Tameside with 66.5% of girls achieving a GLD compared to 54.2% of boys. Nationally girls also outperform boys with 71.9% of girls achieving a GLD and 58.7% of boys.

In 2021/22, 72.3% of Tameside's Year 1 children (6 year olds) were successful in the phonics screening check. This is significantly worse than the England average of 75.5%. However for those children who have a free school meal achieving the expected level in the phonics check – 60%, were not significantly worse than the England average at 62%. Therefore, for this inequality group there has been improvement towards

the non-free school meals group. This could be down to the HAF programme operating in the school holidays, providing more support for some of Tameside's poorest families.

Tameside's Key Stage 1 (at 7 years old) results in reading, writing and maths at Level 2b+ (L2b+) are significantly worse than the England average, showing that the gap between Tameside's children and the national average has gotten wider post COVID-19.

At key stage 2 (11 years old) Tameside has significantly worse outcomes for children than the national average. The proportion of pupils achieving level 4 or better in reading, writing and maths combined in Tameside is 63.4%, compared to 65.3% nationally. Tameside however ranks 43 out of 153 upper tier local authorities in England, although this is the first time period Tameside has been below the England average.

Tameside's average attainment 8 score (16 year olds), is lower than the England average at 45.6 compared to England's 48.7. Comparisons cannot be drawn from previous years, as the attainment 8 is the standard way of monitoring the former GCSE system. Attainment 8 includes English, Math's and Science GCSE's plus other subjects and it replaces the old monitoring of five A*-C GCSE grades. Next year 2022/23 will allow this data to be compared properly and comments made around COVID-19 impacts.

In regards to young people not in education, employment and training (aged between 16 and 18) Tameside is significantly worse than the England average at 8.1% vs England's 4.7% and is on a worsening trend. Currently Tameside ranks as seventh worse out of 153 local authorities in England. More work is required in this area, as this has had a sharp increase in the numbers of young people classified as NEET, post COVID-19.In all, there is considerable work to be done in the area of education and development to ensure our children have the best start in life.

Education however is an ongoing process that does not cease at the age of 16. Increasing employment prospects for stable high quality jobs through education is a proven way to reduce inequalities in this area. Additionally offering education to those with no qualifications increases the qualified workforce and reduces educational inequalities, which can have an entrenched impact on families and cycle of inequalities within Tameside. Below is a table highlighting the level of education 16-64 year olds have achieved within Tameside in 2021.

Post 16 Level of Qualifications

Qualifications (Jan 2021-Dec 2021)

	Tameside (Level)	Tameside (%)	North West (%)	Great Britain (%)
NVQ4 And Above	37,400	26.6	38.6	43.6
NVQ3 And Above	68,600	48.9	58.2	61.5
NVQ2 And Above	103,900	74.0	77.2	78.1
NVQ1 And Above	122,400	87.2	87.2	87.5
Other Qualifications	7,100	5.1	5.2	5.9
No Qualifications	10,800	7.7	7.5	6.6

Source: ONS annual population survey
Notes: For an explanation of the qualification levels see the definitions section.
Numbers and % are for those of aged 16-64
% is a proportion of resident population of area aged 16-64

It shows that just under 8% of our population aged 16-64 (so of working age) has no qualifications at all. Whilst this is not an indicator, of whether someone has a job or not, increasing opportunities to learn post 16 may improve the quality of jobs on offer to the currently unqualified individuals.

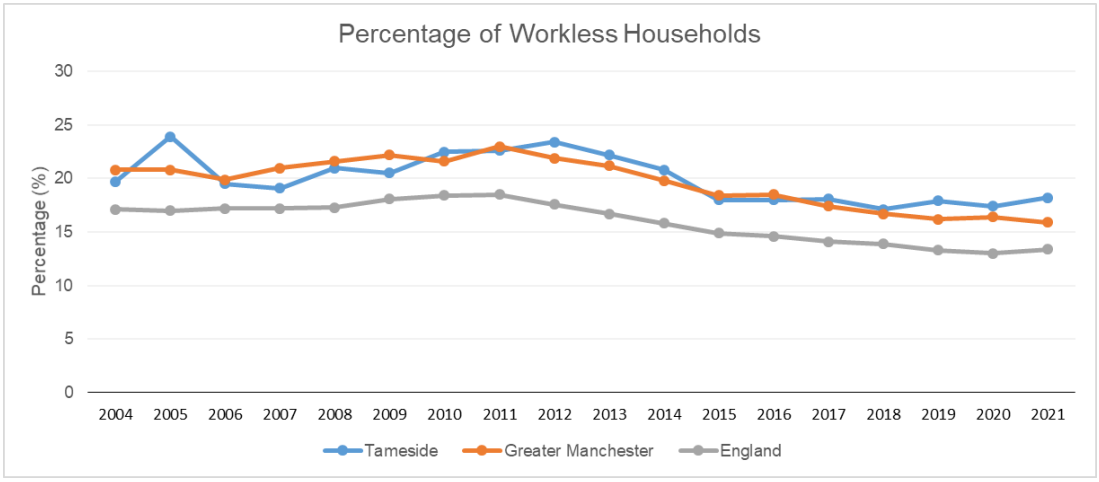
The importance of education and development cannot be overstated, particularly in Tameside where improving educational provision and attainment is essential for the future prosperity of the borough. The first 1000 days of a child's life are critical for their development, and it is important that health visitors closely monitor this period. The attainment of a Good Level of Development in Tameside is significantly worse than the England average, and more work is required in this area to ensure that children have the best start in life. Education is an ongoing process that does not cease at the age of 16, and increasing employment prospects for stable, high-quality jobs through education is a proven way to reduce inequalities. There is also a need to address the growing number of young people who are not in education, employment, or training. With efforts in education and development, Tameside can help to ensure that its residents have the skills and qualifications necessary for a bright and prosperous future.

Work, Employment and Economy

Socioeconomic status has been recognised as a key determinant of inequality in life expectancy. As such, increasing life expectancy for all socioeconomic groups to match the rate of the highest socioeconomic group is a way for Tameside to reduce inequality in life expectancy and ensure that rising life expectancy is of benefit to all individuals regardless of their age and other socioeconomic attributes.

Because of the COVID-19 pandemic, the UK government introduced public health measures to contain the outbreak and bring it under control. The impact of these measures and the virus was a sudden and sharp reduction in economic activity in nearly all sectors in the second quarter of 2020. Since the pandemic the economy, job market and employment activity within Tameside has broadly remained stagnant and, unlike other areas, it is taking longer for Tameside to recover. The below graph highlights the percentage of households in Tameside, Greater Manchester and England who are workless households:

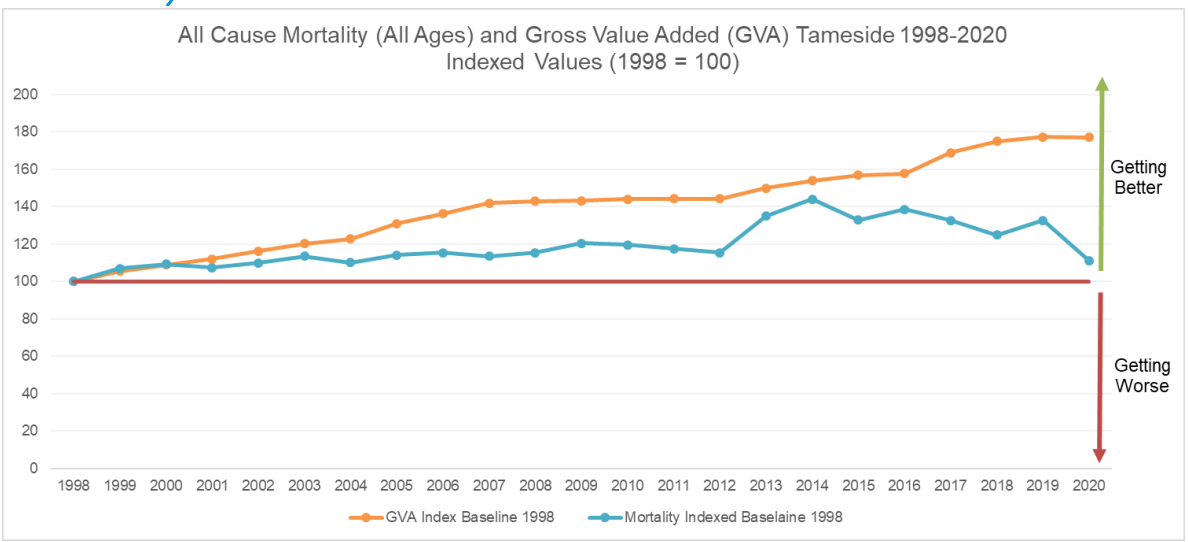
Annual Population Survey Graph Comparing Workless Households



Although over time there has been a decreasing trend, post COVID-19 the trend has been increasing for workless households opposing the Greater Manchester trend. Currently the percentage of workless households in Tameside stands at 18.2%, which is almost a fifth of all households in Tameside.

Improvements in economic performance in Tameside have not been as quick as those seen at a both national and Greater Manchester level. The below graph compares Gross Value Added (GVA) - a measure of the value of goods and services produced by an area per head of the population - and all age all-cause mortality (directly standardised). This is then indexed to 1998 in order to provide a common scale and baseline.

All-Cause Mortality and Gross Value Added in Tameside



It shows that the economy of Tameside has continued to grow, however the COVID-19 pandemic has flat lined the growth in the economy of Tameside. The growth rate however is smaller than that at a UK wide level. In contrast, improvements in all-cause mortality were going well up until the Pandemic and Tameside

Tameside Metropolitan Borough

is now back at the same level as seen 20 years previously. This could explain, like many areas, have experienced the flat lining and post-pandemic worsening life expectancy.

Earnings in the borough are significantly lower than the average at both a North West and England level. A full time worker can expect 11.9% less salary per week than the UK average and 5.2% less salary per week than the North West average. Reflecting both the regional and national averages, female workers are also less likely to receive a higher weekly wage than males, although the gap has been getting progressively smaller over time.

Of those that are economically active within Tameside, 79.2% of males and 72.4% of females are in employment. This is slightly higher than the England average and significantly higher than the North West average. However, in Tameside for both males and females there are less self-employed individuals than at a regional and national level. Because of this, this is a potential area of growth with support for setting up small to medium enterprises SME's in the area to provide more jobs and economic growth.

In relation to jobs and occupations, the below table outlines the employee jobs by industry in Tameside.

Business Register Survey – Employee Jobs in Tameside

Employee jobs (2021)

	Tameside (Employee Jobs)	Tameside (%)	North West (%)	Great Britain (%)
Total Employee Jobs	71,000	-	-	-
Full-Time	48,000	67.6	68.8	68.1
Part-Time	23,000	32.4	31.2	31.9
Employee Jobs By Industry				
B : Mining And Quarrying	0	0.0	0.1	0.1
C : Manufacturing	10,000	14.1	8.6	7.6
D : Electricity, Gas, Steam And Air Conditioning Supply	600	0.8	0.5	0.4
E : Water Supply; Sewerage, Waste Management And Remediation Activities	600	0.8	0.5	0.7
F : Construction	3,500	4.9	5.4	4.9
G : Wholesale And Retail Trade; Repair Of Motor Vehicles And Motorcycles	13,000	18.3	14.6	14.4
H : Transportation And Storage	2,500	3.5	5.4	5.1
I : Accommodation And Food Service Activities	5,000	7.0	7.9	7.5
J : Information And Communication	900	1.3	2.8	4.5
K : Financial And Insurance Activities	1,250	1.8	3.5	3.6
L : Real Estate Activities	1,000	1.4	2.0	1.8
M : Professional, Scientific And Technical Activities	3,000	4.2	8.9	8.9
N : Administrative And Support Service Activities	3,000	4.2	8.3	8.9
O : Public Administration And Defence; Compulsory Social Security	3,000	4.2	4.9	4.6
P : Education	6,000	8.5	7.9	8.8
Q : Human Health And Social Work Activities	15,000	21.1	15.0	13.7
R : Arts, Entertainment And Recreation	1,500	2.1	2.2	2.3
S : Other Service Activities	1,000	1.4	1.5	1.9

Source: ONS Business Register and Employment Survey : open access
- Data unavailable
Notes: % is a proportion of total employee jobs excluding farm-based agriculture
Employee jobs excludes self-employed, government-supported trainees and HM Forces
Data excludes farm-based agriculture

What the table highlights is an over-representative proportion of the Tameside population work in retail, manufacturing and health and social care related fields. These are commonly less well-paid roles than that of finance, I.T. and professional/scientific/technical roles.

In conclusion, the COVID-19 pandemic has had a significant impact on the economy, job market and employment activity within Tameside. The percentage of workless households in the area has increased, and improvements in economic performance have not been as quick as those seen at the national and regional levels. Earnings in the borough are significantly lower than the average at both a North West and England level, and a large proportion of the Tameside population work in less well-paid fields.

Addressing these issues will require targeted efforts to support small to medium enterprises, as well as strategic planning to create better paid roles within the area. By doing so, Tameside can work towards reducing inequality in life expectancy and ensuring that rising life expectancy is of benefit to all individuals, regardless of their socioeconomic status. Therefore, looking at this in a deeper needs assessment may be able to help highlight and plan for growth in more well paid roles within the area.

Food and Nutrition

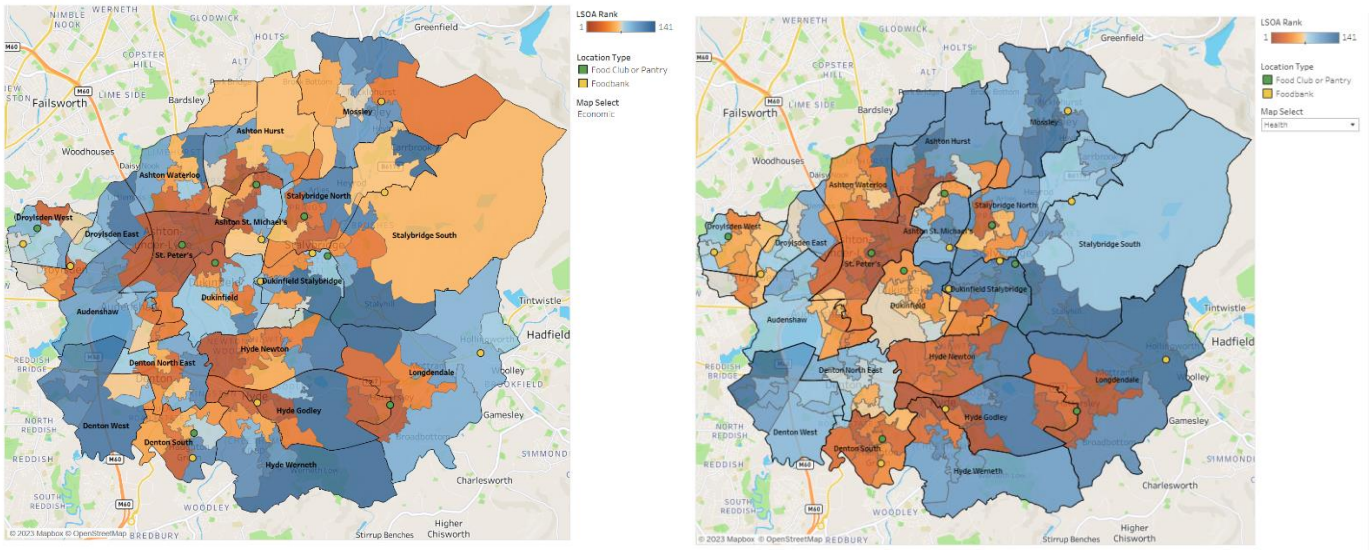
Food insecurity is something that in recent times since the COVID-19 pandemic has been highlighted within Tameside. This relates to the inability to afford, or the uncertainty of access to, nutritionally adequate and safe foods that make up a healthy diet. It is about the quality of food as well as the quantity. Additionally it is not just about hunger but also about being appropriately nourished to be and keep good health and also about the means to access food in a socially acceptable way e.g. without having to resort to food banks, scavenging and stealing. It does not just include people in food poverty, but people and families who worry about their ability to obtain food, compromise on the quality, reduce or skip meals and at the severe end experience hunger.

Using findings from the (The Food Foundation, 2018) report and data from the Census, a local estimate for the number of people or households not spending enough money on food to have a healthy diet has been calculated. Around 109,067 people across the Tameside area are estimated to not spend enough money on food and non-alcoholic drinks each week in order to meet government's guidelines for a healthy diet.

As a subset to food, insecurity is food poverty. The causes of food poverty are complex and inter-related. Financial causes predominate, including low income and unemployment. Other important causes include poor access to affordable food and lack of budgeting or cooking skills. Wider social and economic determinants, such as levels of poverty and welfare reforms, also play a vital role. The consequences of food poverty have major health impacts throughout the life course. These range from hunger, malnutrition and obesity to social consequences such as shame and social exclusion. Evidence shows that poor diet is related to 30% of life years lost in early death and disability. The severity of these consequences shows that failure to act on food poverty will lead to escalating costs for individuals, employers, the NHS and government.

Research as part of the poverty needs assessment within Tameside highlighted that Tameside as an area with particular issues with food poverty. Greater Manchester Poverty Action data shows that 1 in 20 households in Tameside (5.27%) are experiencing hunger, and the percentage of households defined as “experiencing struggle with food insecurity” is the highest in GM at 15.07%. Additionally the Social Market Foundation has also identified Hattersley & Mottram as the third most deprived “food desert” in England. Because of food poverty and food insecurity, this has led to an increase in the amount of foodbanks and food pantries within Tameside. Below details maps of these locations but additionally economic and health rankings for each of the LSOA’s in Tameside.

Foodbank Locations by Economic and Health Ranking within Tameside



The maps highlight that the locations of foodbanks/food pantries are denser in areas of lower health outcomes and lower economic privilege.

Hot food takeaway access in our neighbourhoods affects our dietary choices, body weight and health, and the link with obesity, deprivation and hot food takeaways is strong. In 2018, Tameside had 314 hot food takeaways, which works out at a rate of 139.4 per 100,000 people. This is significantly higher than the England rate of 105.6 per 100,000 people. The table below shows the counts and rates of takeaways for each of the Tameside wards.

Hot Food Takeaways Density by IMD Score (higher score = more deprived)

Ward code	Ward name	Count of Hot Fast Food outlets 2018	Hot Food Takeaway Density per 100,000 Population	Index of Multiple Deprivation (IMD) 2019 Score (Higher score = more deprived)
E05000800	Ashton Hurst	8	69.2	33.5
E05000801	Ashton St Michael's	14	113.5	39.4
E05000802	Ashton Waterloo	9	78	31.6
E05000803	Audenshaw	10	80.7	23.5
E05000804	Denton North East	29	262.2	28.3
E05000805	Denton South	9	82.5	34.1
E05000806	Denton West	12	106.3	20.1
E05000807	Droylsden East	26	215.2	30.3
E05000808	Droylsden West	7	63	28.3
E05000809	Dukinfield	16	124.8	34.7
E05000810	Dukinfield Stalybridge	15	136.3	27.5
E05000811	Hyde Godley	16	131.1	40.8
E05000812	Hyde Newton	11	76.9	32.9
E05000813	Hyde Werneth	14	119.5	26.4
E05000814	Longdendale	8	79.9	34.3
E05000815	Mossley	16	140.9	23.3
E05000816	St Peter's	65	484.5	50.3
E05000817	Stalybridge North	17	131.6	32.5
E05000818	Stalybridge South	12	107.5	22.5
E08000008	**Tameside**	**314**	**139.4**	**31.4**

In 2018, St. Peter's ward in Ashton had the highest rate per population at 484.5, which translates to 65 premises whilst Droylsden West ward has the lowest rate per population at 63, which translates to seven premises.

Work has been carried out in the food insecurity area with schemes such as the slow cooker programme and investment in the bread and butter thing to provide access to food. However as this is a complex issue providing support in other wider determinants of health, areas (as outlined in the Dahlgren and Whitehead model) will have positive impacts on the individuals experiencing food insecurity.

In conclusion, food insecurity is a significant problem in Tameside, particularly due to the COVID-19 pandemic. Food poverty is a subset of food insecurity, and it is caused by various factors such as low income, unemployment, poor access to affordable food, and lack of budgeting or cooking skills. Tameside is an area with specific issues of food poverty, and this has led to an increase in the number of food banks and food pantries in the area. The maps provided highlight that food banks/food pantries are denser in areas of lower health outcomes and lower economic privilege. Moreover, hot food takeaway access in the area affects dietary choices, body weight, and health, and Tameside has a significantly higher rate of hot food takeaways compared to the England rate. The severity of the consequences of food poverty shows that failure to act will lead to escalating costs for individuals, employers, the NHS, and the government. Therefore, addressing food poverty should be a priority, and a multi-faceted approach is necessary to ensure that people have access to nutritionally adequate and safe foods that make up a healthy diet.

Water and Sanitation

The water supply and sanitation of water in Tameside is managed by United Utilities, which provides safe drinking water to over 7 million people across North West England. The water supply in Tameside meets the national standards for quality and safety, and United Utilities regularly conducts tests to ensure the water is safe to drink (United Utilities, 2023). The water supply in Tameside comes from a variety of sources, including reservoirs, rivers, and groundwater. United Utilities manages a network of water treatment plants and pumping stations to ensure that the water is treated and distributed to customers in a timely and efficient manner (United Utilities, 2023). Additionally United Utilities is also responsible for maintaining public sewers, drains, and wastewater treatment plants. The council works closely with United Utilities to ensure that the wastewater is treated to a high standard before being released into the environment. In recent years, there has been a growing focus on water conservation in Tameside, with initiatives aimed at reducing water usage and promoting sustainable practices. For example, United Utilities offers a range of tips and advice on their website for reducing water usage in the home, including fixing leaks, using a water meter, and using water-efficient appliances (United Utilities, 2023). As stated above, United Utilities regularly tests the water supply in Tameside to ensure that it meets the national standards for quality and safety. These tests cover a range of factors, including bacteria, chemicals, and physical characteristics such as colour and odour. The results of these tests are made available to the public through the Drinking Water Quality Reports published by United Utilities (United Utilities). The below table highlights results of the regular testing carried out on Tameside's water supply.

United Utilities Water Analysis 2023

Analysis For Tameside 2023	Typical value	UK/EU limit	Units
(Nitrate)/50 plus (nitrite)/3	0.0279	1	mg/l
1,2-dichloroethane	<0.323	3	µg/l
Alkalinity as CaCO3	15.6		mg/l
Aluminium	<9.82	200	µg Al/l
Ammonium (ammonia and ammonium ions)	<0.0154	0.5	mg NH4/l
Antimony	<0.310	5	µg Sb/l
Arsenic	<0.480	10	µg As/l
Benzene	<0.114	1	µg/l
Benzo(a)pyrene	<0.0020	0.01	µg/l
Boron	<0.0192	1	mg B/l
Bromate	<0.245	10	µg BrO3/l
Cadmium	<0.0900	5	µg Cd/l
Calcium	10.9		mg Ca/l
Chloride	10	250	mg Cl/l
Chromium	<0.830	50	µg Cr/l
Clostridium perfringens (including spores)	0	0	number/100ml
Coliform bacteria	0	0	number/100ml
Colony counts after 3 days at 22 deg C	0		number/1ml
Colour	<1.78	20	mg/l Pt/Co scale
Conductivity	105	2500	uS/cm at 20oC
Copper	<0.0140	2	mg Cu/l
Cyanide	<3.91	50	µg CN/l
E.coli	0	0	number/100ml
Enterococci	0	0	number/100ml
Fluoride	<0.120	1.5	mg F/l
Glyphosate	<0.0080	0.1	µg/l
Hardness Clarke	2.45		Clarke
Hardness Level	Soft		
Hardness Total as CaCO3	35		mg CaCO3/l
Hydrogen ion (pH)	7.31	9.5	pH value
Iron	<13.0	200	µg Fe/l
Lead	<0.554	10	µg Pb/l
Magnesium	1.81		mg Mg/l
Manganese	<1.31	50	µg Mn/l
MCPA	<0.0148	0.1	µg/l
Mercury	<0.130	1	µg Hg/l

Analysis For Tameside 2023	Typical value	UK/EU limit	Units
Nickel	<1.07	20	µg Ni/l
Nitrate	<1.77	50	mg NO3/l
Nitrite	<0.0115	0.5	mg NO2/l
Odour (quantitative)	0	0	dilution number at 25oC
Pesticides - Total	0	0.5	µg/l
Polycyclic aromatic hydrocarbons (sum of 4 PAHs)	0	0.1	µg/l
Residual chlorine - Free	0.87		mg/l
Residual chlorine - Total	0.95		mg/l
Selenium	<0.850	10	µg Se/l
Sodium	8.55	200	mg Na/l
Sulphate	18.4	250	mg SO4/l
Taste (quantitative)	0	0	dilution number at 25oC
Tetrachloroethene and trichloroethene	0	10	µg/l
Tetrachloromethane	<0.186	3	µg/l
Total organic carbon	1.14		mg C/l
Trihalomethanes - Total	29.8	100	µg/l
Turbidity	<0.20	4	NTU

In all the data highlights the following:

- Bacteria Levels: The reports indicate that bacteria levels in the Tameside water supply are well below the national standards for safe drinking water. In fact, over 99.9% of samples taken from Tameside meet the standards for total coliform bacteria, which is an indicator of the overall microbial quality of the water supply.

- Chemical Contaminants: The reports also show that levels of chemical contaminants in the Tameside water supply are well within the national standards for safe drinking water. United Utilities tests for a wide range of chemicals, including pesticides, metals, and disinfection by-products, and the results show that levels of these contaminants are consistently low.

- Taste and Odor: The reports also provide information on the taste and odor of the Tameside water supply. United Utilities monitors these factors closely and takes action if there are any issues reported by customers. The reports indicate that taste and odor issues are rare in the Tameside water supply and are usually resolved quickly.

- Fluoridation: Tameside along with the rest of Greater Manchester do not have added fluoride in drinking water. Fluoridation levels remain significantly lower than elsewhere in the UK and further investigation may be required in this area, in respect of Oral Health outcomes of people in Tameside.

Tameside Metropolitan Borough Council provides services in Tameside around environmental sanitation. The Council is responsible for a range of services to residents, including the collection of household waste and recycling (Tameside MBC, 2023), pest control services (Tameside MBC, 2023), food hygiene and piercing/tattoo hygiene (Tameside MBC, 2023). Whilst there was an increase slightly in fly tipping incidents, all levels of sanitisation Tameside Council provides is back to pre-pandemic levels.

Overall, water, sanitisation and environmental sanitation are services provided daily within Tameside and all agencies involved work together to make Tameside safe and sanitary. Further investigation into oral health in Tameside is required and details on fluoridation of water in order to drive up health outcomes in this area.

Housing

Housing is an important social determinant of health, and the connection between both has been widely researched and is strong. Housing affordability, both to rent and to buy, affects where people live and work and by an area having the right balance, it can attract and retain a strong employable workforce. Factors in relation to housing that influence health include the quality of housing available, poverty, community cohesion, and time spent commuting to school/work. There is increasing evidence of a direct association between unaffordable housing and poor mental and physical health (The Health Foundation, 2023), even

more so than just being in poverty. Taken form the 2020 Tameside Housing Needs Assessment, across Tameside there are an estimated 102,890 dwellings and 98,594 households and 2.3% of dwellings are vacant.

In terms of housing stock: 63.4% of occupied dwellings are owner occupied, 14.2% are private rented and 22.4% are affordable (including social/affordable renting and shared ownership). In relation to the types of housing in the borough, currently: 78% of dwellings are houses (39.6% terraced, 30.3% semi-detached, 8.1% detached), 15.3% are flats and 6.7% are bungalows. In regards to council tax, 70.5% of homes are in council tax band A or B properties and 29.5% are band C or above. The types of homes in Tameside currently consist of 10% having 1-bedroom, 38.1% two-bedrooms, 44.5% three-bedrooms and 7.4% for or more bedrooms. Additionally quite a lot of housing in Tameside is older types of properties with 42.6% of dwellings built before 1945 and an estimated 21.8% of all dwelling stock is non-decent. Over the past 13 years an annual average of 460 dwellings have been built across Tameside although a target of 660 is required per year to keep up with demand.

Homelessness in Tameside is also a key determinant of health and is often associated with poverty and deprivation. Tameside council has a statutory duty to homeless households where a household must have become unintentionally homeless and must be considered to be in priority need. Because of this, homeless households contain some of the most vulnerable and high service need members of Tameside. There are a number of risk factors associated with the likelihood of someone becoming homeless, ranging from drug and alcohol issues, bereavement, or experience of the criminal justice system, to inequality, unemployment, and housing supply and affordability. The majority of the people that are found to be homeless but not in priority need are single homeless people, who as a group have very high prevalence of mental and physical health issues.

In relation to summary indicators around housing, the below table highlights data around housing and homelessness in Tameside taken from (Office for Health Improvement and Disparities, 2023).

Fingertips – Housing Indicators for Tameside

Indicator	Period	Tameside			Region	England	England		
		Recent Trend	Count	Value	Value	Value	Worst	Range	Best
Statutory homelessness: rate per 1,000 households	2017/18	–	-	-	-	-	-		-
Overcrowded households	2011	–	3,861	4.1%	3.7%	4.8%	25.4%		1.3%
Children in low income families (all dependent children under 20)	2016	↓	9,940	19.0%	18.1%	17.0%	32.5%		2.8%
Affordability of home ownership	2021	–	171,000	6.2	6.4	9.1	24.8		4.4
Households with overcrowding based on overall room occupancy levels	2011	–	5,815	6.1%	-	8.7%	34.9%		2.5%
Modelled estimates of the proportion of households in fuel poverty (%)	2020	–	14,379	14.1%	-	13.2%	22.4%		4.4%
Children in relative low income families (under 16s)	2020/21	→	10,234	22.3%	21.2%	18.5%	42.4%		3.3%
Children in absolute low income families (under 16s)	2020/21	→	8,073	17.6%	16.6%	15.1%	39.2%		2.7%
Homelessness - households in temporary accommodation	2020/21	–	158	1.6	1.6	4.0	48.6		0.1
Homelessness - households owed a duty under the Homelessness Reduction Act	2020/21	–	1,130	11.4	11.9	11.3	26.6		0.0
Homelessness - households owed a duty under the Homelessness Reduction Act (main applicant 16-24 yrs)	2020/21	–	205	2.1	2.7	2.6	6.2		0.0
Homelessness - households owed a duty under the Homelessness Reduction Act (main applicant 55+ yrs)	2020/21	–	97	2.2	2.1	2.3	10.7		0.5
Homelessness - households with dependent children owed a duty under the Homelessness Reduction Act	2020/21	–	245	9.0	12.3	11.6	32.2		3.6
Fuel poverty (low income, low energy efficiency methodology)	2020	–	14,379	14.1%	14.4%	13.2%	22.4%		4.4%

The data shows that for low income and fuel poverty Tameside is significantly worse than the England average, and additionally for overcrowding in households. Tameside is however significantly better in relation to homelessness, showing targeted work to improve the inequalities faced by this population. In addition, work has been conducted following the housing needs assessment in Tameside to improve the quality of houses, build and repurpose homes into the required type of housing and build more houses to keep up with demand. In summary, housing is an important social determinant of health, and the quality, affordability, and availability of housing can have a significant impact on people's physical and mental well-being. Tameside, like many areas, faces challenges around housing affordability and homelessness, which can contribute to health inequalities. However, there are ongoing efforts to address these challenges and improve the quality and quantity of housing in the area. For further details, please see the Tameside Housing Needs Assessment: https://www.tameside.gov.uk/TamesideMBC/media/housing/HNA-2020.pdf.

Air Quality and Environmental Factors

Poor air quality is associated with a number of adverse health problems and is recognised as a contributing factor in the onset of asthma, heart disease and cancer. Additionally, air pollution particularly affects the most vulnerable in society, including those in poverty, children and older people, and those with heart and lung conditions. There is also often a strong connection with inequalities, because areas with poor air quality are also often the less affluent areas.

Air Quality Management Areas (AQMAs) are areas that are likely to exceed the national air quality objective for a specific pollutant. Tameside has an AQMA, which 3.5% of the Tameside population live within. This AQMA is now also part of the Greater Manchester Combined Authority AQMA. Tameside Council works with Clean Air GM on improving local air quality. Long term trends show that there has been an improvement in air quality but areas still remain above the annual mean air quality objective for fine particulate matter (PM2.5) and Tameside is the second highest in the North West of England.

Greater Manchester's Clean Air Plan (Greater Manchester Clean Air Plan, 2023) identifies the following broad actions to improve air quality:

- Targeting the most polluted areas: Modelling shows that NO_2 exceedances become more localised from 2025 onwards, with breaches only forecast at specific locations. As a result, action can be targeted at those locations suffering the worst air quality.
- Targeted funding: Using the £120 million government Clean Air funding already awarded for vehicle upgrades, rather than imposing daily charges. Funding will be targeted to clean up the most polluting vehicles that travel frequently on the most polluted local roads. These roads are predicted to exceed legal limits for nitrogen dioxide if we do not take action.
- Cleaning up polluting buses: Nearly 90 per cent of Greater Manchester's bus fleet already meets government emission standards thanks to the government Clean Air Bus fund.
- Local policy changes: We will review local policies (such as goods vehicle access controls) as well as regulatory measures (such as hackney carriage and private hire vehicle licensing standards) to speed up fleet upgrades.
- Cycling: Existing strategies and initiatives to encourage cycling.

In relation to air quality and environmental noise, the below indicators highlight Tameside's position taken from (Office for Health Improvement and Disparities, 2023).

Fingertips – Air Quality Indicators

Indicator	Period	Tameside			Region	England	England		
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Fraction of mortality attributable to particulate air pollution (old method)	2019	–	-	5.2%	4.5%	5.1%	2.2%		7.0%
The percentage of the population exposed to road, rail and air transport noise of 65dB(A) or more, during the daytime	2016	–	12,280	5.5%	5.5%	5.5%	27.7%		0.9%
The percentage of the population exposed to road, rail and air transport noise of 55 dB(A) or more during the night-time	2016	–	18,460	8.3%	9.4%	8.5%	37.0%		1.3%
Air pollution: fine particulate matter (historic indicator)	2020	–	-	7.1	6.1	6.9	10.0		4.0
Proportion of population living within AQMAs (%)	2017	–	-	3.5	-	-	-		-
Fraction of mortality attributable to particulate air pollution (new method)	2020	–	-	5.7%	5.0%	5.6%	3.4%		7.8%
Air pollution: fine particulate matter (new method - concentrations of total PM2.5)	2020	–	-	7.6	6.7	7.5	10.6		4.5

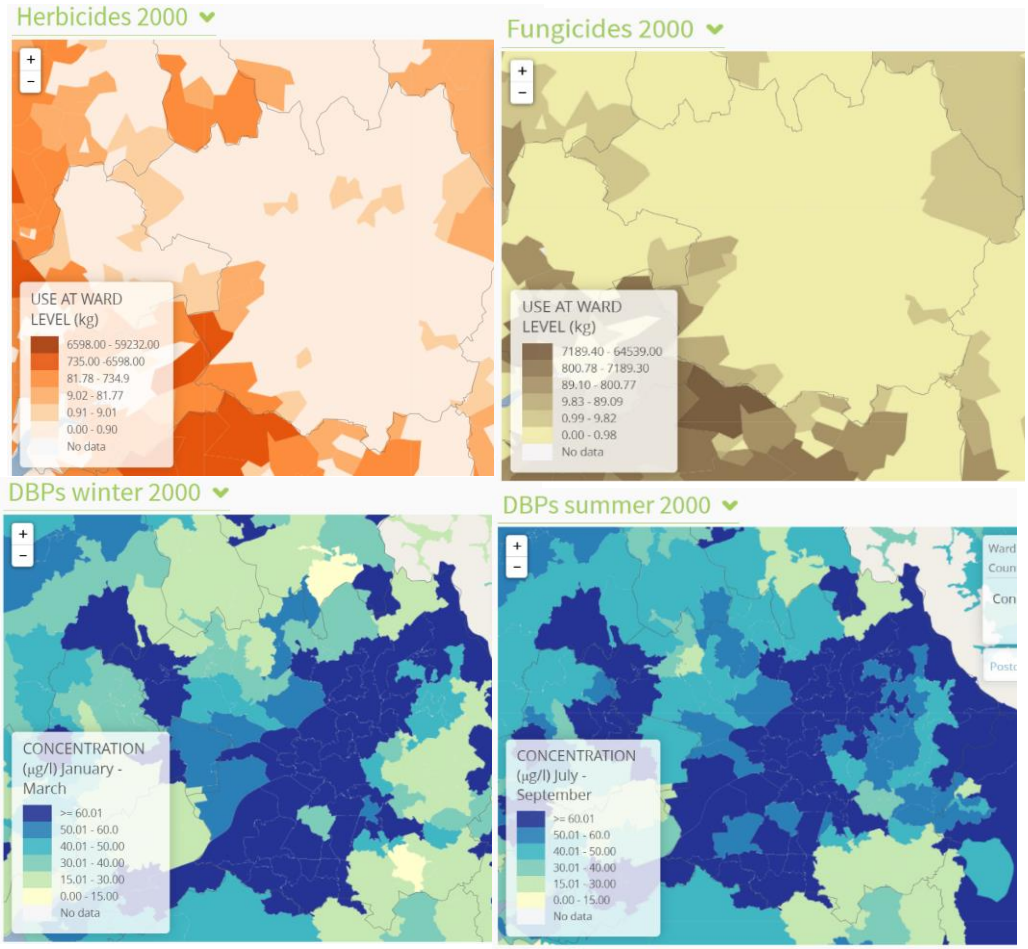
For all area's it broadly reflects that Tameside is around the England average. It should be noted however that air quality is attributable to 5.7% of mortality each year in Tameside (using the new method of calculation).

(Public Health England, 2018) - now the Office for Health Improvement and Disparities produced a tool which estimates the healthcare cost and burden of disease owing to the air quality directly in Tameside. In 2023, it is estimated that air pollution will cost Tameside £1,538,433 in combined costs across the health and social care system (primary and secondary care, medication and social care costs). This will only increase with time with a predicted cost of £2,121,647 by the year 2033. In order to prevent the costs from increasing, working with GM around the air quality plan will helps to reduce emissions. Additionally schemes such as the pre-

loved bicycles run within the Population Health team, also encourage both less journeys being carried out by polluting vehicles and an active Tameside increasing fitness and exercise within the borough.

Environmental factors and health are more than just around air quality, they are also about chemicals in the ground, noise complaints, fly tipping, and food standards and anything in relation to the environment, we experience our everyday lives in.

MSOA Maps Environmental Factors



According to (Small Area Health Statistics Unit (MRZC-PHE and Imperial Colledge London), 2023), Tameside has:

- Low levels of Herbicide and Fungicide use except around Mossley and Stalybridge where moderate amounts of both are used. This fits with where agricultural land is in the borough.
- High levels in both summer and winter of Chlorination disinfection by products in public water supplies, although this is still well within targets set by the EU (and subsequently UK since Brit-exit).

Taken form (Office for Health Improvement and Disparities, 2023) the below indicators give information on noise complains in the borough and utilisation of outdoor space for exercise.

Fingertips – Environmental Living Conditions

Indicator	Period	Tameside			Region	England	England		
		Recent Trend	Count	Value	Value	Value	Worst	Range	Best
The rate of complaints about noise	2019/20	➡	1,065	4.7*	3.7*	6.4*	80.4		0.7
Utilisation of outdoor space for exercise/health reasons	Mar 2015 - Feb 2016	–	-	14.5%	17.5%	17.9%	5.1%		36.9%

It shows that Tameside is slightly significantly better for complains about noise, displaying Environmental Health and Community Safety partnerships work in this area. However, exercise in outdoor space has been

lower, although not significantly different from the England average. As there is no data post COVID-19 and many schemes have been produced in this area, there has likely been an increase in the use in Tameside. Overall, poor air quality and environmental factors have significant impacts on public health, particularly for vulnerable populations. Tameside is working towards improving air quality through targeted actions, but more work is needed to meet national air quality objectives. Environmental factors beyond air quality, such as chemicals in the ground and noise complaints, also affect our daily lives and should not be overlooked. It is important for local communities and authorities to continue to address these issues to ensure a healthier and safer environment for everyone.

Health, Care and Mortality

Health Protection

Health protection is actions we might take to protect the population's health from major incidents such as COVID-19, and threats such as increasing preventable cancers. This is carried out through a number of preventative and action programmes from immunisations and vaccinations, screening for diseases, sexual health services and screening, antibiotic prescription monitoring and the monitoring and actions around outbreaks of disease (such as during the COVID-19 pandemic).

Immunisations and Vaccinations

In relation to vaccinations, coverage in Tameside is generally good with immunisation rates above 90% and some over the recommended 95 per cent target rate for vaccines according to (Office for Health Improvement and Disparities, 2023). The exceptions to this are for the following vaccinations:

- Rotavirus (Rota) (1 year) - The rotavirus vaccine protects against gastroenteritis. The vaccine was introduced into the routine childhood immunisation programme in 2013 for babies at 8 and 12 weeks of age. In Tameside, we only have a 89.9% coverage.
- DTaP and IPV booster (5 years) - A booster vaccine for diphtheria, tetanus, pertussis and polio disease has been in the routine childhood immunisation programme since late 2001. It is currently offered at 3 year and 4 months or soon after. In Tameside, we only have a 88.8% coverage.
- In relation to Flu and Shingles vaccines, the target value is 55% for flu and 50% for Shingles. For at risk individuals for flu vaccine uptake there is only a 50.8% coverage and this has been on a decreasing trend. For shingles in Tameside, there is only a 42.8% uptake and Tameside is in the lowest 25% percentile for uptake nationally.

Uptake for vaccines in Tameside is lower in the areas of highest deprivation and this gap has only been highlighted further since the COVID-19 pandemic.

Screening

Screening is the process of identifying apparently healthy people who may have an increased chance of a disease or condition. This means that upon being seen by a professional they can then be offered information, further tests and treatment, in the case of a disease being found. Screening is ultimately to reduce associated problems or complications and help in the early identification of diseases. In Tameside for standard screening, such as for bowel and breast cancers, health checks and newborn screening; Tameside is worse than the England average except for Cervical screening at 25-49 years old. The below highlights the most recent data on screening in Tameside from (Office for Health Improvement and Disparities, 2023).

Fingertips – Screening Indicators

Indicator	Period	Tameside			Region	England	England		
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
C23 - Percentage of cancers diagnosed at stages 1 and 2 New data	2020	→	473	51.6%	51.2%	52.3%	42.0%		61.3%
C24a - Cancer screening coverage: breast cancer New data	2022	↓	16,328	62.3%	63.3%*	65.2%*	40.2%		79.6%
C24b - Cancer screening coverage: cervical cancer (aged 25 to 49 years old) New data	2022	→	29,542	71.5%	68.9%*	67.6%*	42.6%		82.5%
C24c - Cancer screening coverage: cervical cancer (aged 50 to 64 years old) New data	2022	↓	15,860	73.3%	73.8%*	74.6%*	53.7%		83.5%
C24d - Cancer screening coverage: bowel cancer New data	2022	↑	25,104	66.6%	68.0%*	70.3%*	51.2%		79.4%
C24e - Abdominal Aortic Aneurysm Screening Coverage New data	2021/22	↓	497	40.0%	50.4%*	70.3%*	10.5%		91.0%
Infectious Diseases in Pregnancy Screening: HIV Coverage	2017/18	–	-	-	99.2%*	99.6%*	-	*Insufficient number of values for a spine chart*	-
Sickle Cell and Thalassaemia Screening: Coverage	2016/17	–	-	-	98.8%	99.3%	-	*Insufficient number of values for a spine chart*	-
Newborn Blood Spot Screening: Coverage	2017/18	–	-	-	97.9%*	96.7%*	-	*Insufficient number of values for a spine chart*	-
Newborn Hearing Screening: Coverage New data	2021/22	→	2,476	97.9%	98.1%*	98.7%*	82.1%		100%
Newborn and Infant Physical Examination Screening Coverage New data	2021/22	–	2,420	94.8%	95.8%*	96.6%*	92.0%		100%
Cumulative percentage of the eligible population aged 40-74 offered an NHS Health Check	2017/18 - 21/22	–	32,558	50.0%	80.2%	63.3%	4.7%		100%
Cumulative percentage of the eligible population aged 40-74 offered an NHS Health Check who received an NHS Health Check	2017/18 - 21/22	–	15,305	47.0%	41.8%	44.8%	15.6%		100.0%
Cumulative percentage of the eligible population aged 40-74 who received an NHS Health check	2017/18 - 21/22	–	-	23.5%	33.5%	28.4%	1.7%		65.2%

More work is required in this area to understand why screening uptake is low. Some of the data suggests this is currently because of the aftermath of the COVID-19 pandemic and the current struggle to get GP and hospital appointments. A recommendation is a monitoring dashboard to highlight trends over time in this area.

Sexual Health

Sexual health is as valuable as any other type of health and how important it is will be different for each person. Sexual health is an important part of your physical and mental health, as well as your emotional and social well-being. It is important to take care of your sexual health and within Public Health; services are specifically commissioned to support sexual health and wellbeing in Tameside. These services include sexual health screening, testing, contraception and terminations of pregnancy.

Below is a summary of the key indicators taken from (Office for Health Improvement and Disparities, 2023) in relation to sexual health.

Fingertips – Sexual Health Indicators

Indicator	Period	Tameside			Region	England	England		
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Syphilis diagnostic rate per 100,000	2021	→	55	24.2	11.0	13.3	145.7		0.0
Gonorrhoea diagnostic rate per 100,000	2021	→	153	67	67	90	1,006		11
Chlamydia detection rate per 100,000 aged 15 to 24	2021	↓	244	1,004	1,330	1,334	382		3,063
Chlamydia proportion aged 15 to 24 screened	2021	↓	2,616	10.8%	13.7%	14.8%	5.5%		40.6%
New STI diagnoses (excluding chlamydia aged under 25) per 100,000	2021	↓	-	299	322	394	2,634		103
HIV testing coverage, total	2021	↓	2,698	43.3%	41.8%	45.8%	17.0%		82.9%
HIV late diagnosis in people first diagnosed with HIV in the UK <25% 25% to 50% ≥50%	2019 - 21	–	9	52.9%	40.7%	43.4%	100%		0.0%
New HIV diagnosis rate per 100,000	2021	↓	3	1.3	4.4	4.8	22.2		0.0
HIV diagnosed prevalence rate per 1,000 aged 15 to 59 <2 2 to 5 ≥5	2021	→	293	2.24	2.06	2.34	12.67		0.59
Population vaccination coverage: HPV vaccination coverage for one dose (12 to 13 year old) (Female) <80% 80% to 90% ≥90%	2020/21	→	1,330	91.7%	79.5%	76.7%	25.0%		98.3%
Under 25s repeat abortions (%)	2021	→	152	38.4%	31.9%	29.7%	39.8%		17.3%
Abortions under 10 weeks (%)	2021	↑	1,068	91.6%	89.6%	88.6%	79.9%		92.2%
Total prescribed LARC excluding injections rate / 1,000	2021	↓	-	38.8	37.8	41.8	4.4		75.1
Under 18s conception rate / 1,000	2020	→	72	19.4	16.7	13.0	30.4		2.7
Under 18s conceptions leading to abortion (%)	2020	→	39	54.2%	54.4%	53.0%	24.3%		82.9%
Violent crime - sexual offences per 1,000 population	2021/22	→	755	3.3	3.5*	3.0*	1.4		6.3

Since COVID-19 Tameside now has the third worse, repeat abortion rate for under 25's in England. A new sexual health service has been commissioned and work around this area is underway, including a full sexual health-monitoring dashboard. Upon exploring terminations from local data, there is a link between higher rates of terminations and areas that are more deprived. This appears to have been highlighted more because of the current economic climate and post COVID-19.

Antibiotic Prescribing

Reductions in antibiotic consumption is a well-recognised target in antimicrobial resistance (AMR) policies. Antimicrobial resistance arises when the organisms that cause infection evolve ways to survive treatments. The term antimicrobial includes antibiotic, antiprotozoal, antiviral and antifungal medicines. In recent times as less antibiotics have been developed, there has been an increase in cases of antimicrobial infections such as MRSA. Within Tameside, there is significantly better prescribing rates than the 2012/13 benchmark and Tameside is around the England average for prescribing rates.

Infectious Diseases

NHS England and now the Integrated Care Boards are responsible for commissioning specialised services to deal with around 100 less common infectious diseases to ensure that people receive high-quality care whilst safeguarding against the spread of diseases. This includes diseases such as scarlet fever, measles, Salmonella, Tuberculosis etc. If an outbreak is identified in the Tameside area, the local health protection team are notified and contact tracing and disease spread prevention measures are put into place.
The below indicators taken from (Office for Health Improvement and Disparities, 2023) highlight some of the indicators around infectious diseases.

Fingertips – Infectious Diseases

Indicator	Period	Tameside		Region	England	England		
		Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Acute Lyme disease laboratory confirmed incidence rate/100,000 New data	2022	0	0.0	0.8	1.5	9.3		0.0
Scarlet fever notification rate/100,000 aged 0-9 yrs	2016	136	467	275*	230	612		2
Campylobacter incidence rate/100,000	2017	58	26.0	95.7*	96.6	174.3		15.5
Typhoid & paratyphoid incidence rate/100,000 New data	2019	4	1.77	1.13*	0.74	7.36		0.00
Non-typhoidal Salmonella incidence rate/100,000	2017	26	11.6	14.6*	15.7	46.7		7.8
Giardia incidence rate/100,000	2017	0	0.0	4.8*	8.5	51.2		0.0
Cryptosporidium incidence rate/100,000	2017	2	0.9	7.7*	7.3	21.9		0.0
Shigella incidence rate/100,000	2017	2	0.9	2.4*	3.5	46.4		0.0
STEC (Shiga toxin-producing Escherichia coli) serogroup O157 incidence rate/100,000	2018	0	0.0	1.1*	1.0	4.3		0.0
STEC (Shiga toxin-producing Escherichia coli) serogroup O157 5-year incidence rate/100,000	2014 - 18	12	1.08	1.39*	1.15	2.80		0.00
Listeria incidence rate/100,000	2018	0	0.00	0.21*	0.26	2.16		0.00
Listeria 5-year incidence rate/100,000	2014 - 18	3	0.27	0.25*	0.27	1.37		0.00
Invasive Meningococcal Disease (IMD) confirmed cases rate/100,000	Jul 2020 - Jun 2021	1	0.4	0.2	0.1	1.3		0.0
Measles incidence rate/100,000 New data	2021	0	0.0	0.0	0.0	0.7		0.0
Measles 5-year incidence rate/100,000	2017 - 21	0	0.0	0.4	0.8	11.5		0.0
Mumps incidence rate/100,000	2018	2	0.9	6.9*	1.9	39.0		0.0
Mumps 5-year incidence rate/100,000 New data	2012 - 16	30	2.7	4.3	3.6	19.7		0.5
Proportion of pulmonary TB cases starting treatment within four months of symptom onset	2020	-	-	67.4%*	67.6%	-	*Insufficient number of values for a spine chart*	-
Proportion of drug sensitive TB cases who had completed a full course of treatment by 12 months	2019	-	88.2%	81.6%	82.0%	20.0%		100%
Proportion of TB cases offered an HIV test	2020	11	100%	-	97.4%	71.4%		100%
Population vaccination coverage BCG: areas offering universal BCG only	2021/22	498	*	*	*	-	-	-
Legionnaires' disease confirmed incidence rate/100,000	2016	1	0.45	0.47*	0.61	2.34		0.00

Broadly speaking the levels of infectious disease are not significantly different from the England average. However, as discussed in further detail below, premature mortality for infectious and communicable diseases is significantly worse than the England average.

In conclusion, health protection is a critical aspect of public and population health that aims to protect the population's health from major incidents and threats. The preventative and action programmes involved in health protection include immunisations and vaccinations, screening for diseases, sexual health services and screening, antibiotic prescription monitoring, and outbreak monitoring and management. In Tameside, immunisation coverage is generally good, but more work is needed to increase uptake in some areas. Screening uptake is lower than the England average, except for cervical screening. Sexual health indicators suggest that there is a need for improved services, particularly for young people – with the new commission of Locala hoping to address this. Antibiotic prescribing rates in Tameside are around the England average, and infectious disease levels are similar to the national average. However, premature mortality for infectious and communicable diseases is significantly worse than the England average, indicating a need for further action in this area. A monitoring dashboard could help highlight trends over time and aid in the ongoing management of health protection in Tameside.

Primary Care and General Practice

Primary care services in Tameside are provided by a range of healthcare professionals, including general practitioners (GPs), nurses, pharmacists, and other healthcare professionals. These professionals work together to provide a comprehensive and integrated approach to healthcare delivery. Primary care is often the first point of contact for people in need of healthcare, and these services are widely available within Tameside and currently over 220,000 people are registered with a Tameside GP practice.

The Greater Manchester Integrated Care Board (ICB) and Tameside Sub-ICB is responsible for the planning and commissioning of primary care services in the area. The Tameside Sub-ICB works closely with local healthcare providers, such as Tameside and Glossop Integrated Care Foundation Trust, to ensure that primary care services meet the needs of the local population.

Primary care services in Tameside include general medical services, which are provided by GPs and their practice teams. These services include diagnosis and treatment of illness and injury, ongoing management of chronic conditions, and preventive care such as immunisations and health screenings.

One of the key challenges facing primary care in Tameside is the need to address health inequalities in the area. Tameside has higher rates of chronic illness and poor health outcomes compared to the national average. Primary care services need to be tailored to the needs of the local population and delivered in a way that addresses these inequalities.

According to the National Health Service's (NHS) Quality Outcomes Framework (QOF) data from 2021/22, Tameside sub ICB achieved an overall QOF score of 90.4%, which is below the national average of 91.8%. The QOF is a system used in the UK to measure the quality of care provided by GP practices against a set of national standards and indicators. The indicators include various areas of care, such as management of long-term conditions, preventive care, and patient experience. According to the data in the QOF, the percentage of patients who reported having a good experience with their GP practice in Tameside was 68%, which is below the national average of 82.8%. Additionally, the data shows that the percentage of patients who were able to get an appointment within two days with their GP practice in Tameside was 48.2%, which is below the national average of 62.1%.

Fingertips – QOF and Long-Term Condition Indicators

Indicator	Period	Greater Manchester ICB - 01Y			ICBs	England	England		
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
QOF Total List Size	2021/22	–	220,577	220,577	3,160,705	61,604,213	-	-	-
Learning disability: QOF prevalence (all ages)	2021/22	↑	1,492	0.7%	0.6%	0.5%	0.3%		0.9%
Stroke: QOF prevalence (all ages)	2021/22	–	4,444	2.0%	1.8%	1.8%	1.0%		2.9%
Hypertension: QOF prevalence (all ages)	2021/22	→	34,885	15.8%	13.2%	14.0%	9.6%		19.3%
Epilepsy: QOF prevalence (18+ yrs)	2021/22	–	1,718	1.0%	0.9%	0.8%	0.5%		1.2%
Diabetes: QOF prevalence (17+ yrs)	2021/22	↑	14,897	8.5%	7.5%	7.3%	4.4%		9.9%
Dementia: QOF prevalence (all ages)	2021/22	–	1,714	0.8%	0.7%	0.7%	0.4%		1.2%
COPD: QOF prevalence (all ages)	2021/22	–	6,313	2.9%	2.2%	1.9%	0.9%		3.7%
CKD: QOF prevalence (18+ yrs)	2021/22	–	4,673	2.7%	3.7%	4.0%	2.1%		6.9%
Heart Failure: QOF prevalence (all ages)	2021/22	–	2,301	1.0%	0.9%	1.0%	0.5%		1.8%
CHD: QOF prevalence (all ages)	2021/22	–	8,162	3.7%	3.0%	3.0%	1.8%		4.8%
Cancer: QOF prevalence (all ages)	2021/22	–	7,156	3.2%	2.9%	3.3%	1.7%		5.0%
Atrial fibrillation: QOF prevalence (all ages)	2021/22	→	4,334	2.0%	1.8%	2.1%	0.9%		3.5%
Asthma: QOF prevalence (all ages) - retired after 2019/20 (now 6+ yrs)	2019/20	–	-	-	6.9%*	6.5%	5.0%		8.3%
Palliative/supportive care: QOF prevalence (all ages)	2021/22	↑	2,078	0.9%	0.4%	0.5%	0.2%		1.2%
% QOF points achieved	2021/22	↓	-	90.4%	91.5%	91.8%	82.8%		97.2%
Depression: QOF prevalence (18+ yrs)	2021/22	↑	-	17.0%	14.8%	12.7%	7.4%		20.6%
Heart failure with LVSD: QOF prevalence (all ages)	2021/22	–	835	0.4%	0.4%	0.4%	0.2%		1.1%
Osteoporosis: QOF prevalence (50+ yrs)	2021/22	→	547	0.7%	0.6%	0.8%	0.2%		2.0%
Mental Health: QOF prevalence (all ages)	2021/22	→	1,998	0.91%	1.06%	0.95%	0.63%		1.58%
Depression: QOF incidence (18+ yrs) - new diagnosis	2021/22	–	3,491	2.0%	2.0%	1.5%	1.0%		2.9%
Asthma: QOF prevalence (6+ yrs) New data	2021/22	–	15,240	7.4%	6.9%	6.5%	4.5%		8.2%
Rheumatoid Arthritis: QOF prevalence (16+ yrs)	2021/22	→	1,436	0.8%	0.7%	0.8%	0.5%		1.2%
Smoking: QOF prevalence (15+ yrs)	2021/22	↓	33,169	18.4%	16.5%	15.2%	11.5%		23.5%
Estimated percentage of detected Atrial Fibrillation	2018/19	–	-	-	-	80.0%	-	*Insufficient number of values for a spine chart*	-
Obesity: QOF prevalence (18+ yrs)	2021/22	–	18,323	10.6%	10.2%	9.7%	5.5%		15.4%
CVD-PP: QOF prevalence (30-74 yrs) - retired after 2019/20	2019/20	–	-	-	-	1.2%	0.5%		1.8%
PAD: QOF prevalence (all ages)	2021/22	–	1,875	0.9%	0.7%	0.6%	0.3%		1.1%
Non-Diabetic Hyperglycaemia (NDH): QOF prevalence (18+ yrs)	2021/22	–	11,016	6.4%	7.5%	6.1%	2.2%		10.6%

Tameside Metropolitan Borough

Regarding long-term conditions in Tameside, the data from (Office for Health Improvement and Disparities, 2023) shows that the prevalence of long-term conditions in the area is higher than the national average. Specifically, the data shows that the percentage of the Tameside population registered with a GP who have at least one long-term condition is 59.7%, which is above the national average of 53.5%.

Furthermore, the data shows that the prevalence of specific long-term conditions in Tameside is higher than the national average for several conditions, including chronic obstructive pulmonary disease (COPD), diabetes, and cardiovascular disease. For example, the data shows that the age-standardised prevalence of diabetes in Tameside is 8.5%, which is above the national average of 4.4%.

In terms of management of long-term conditions, the data shows that the percentage of patients with Asthma in Tameside who had received a review in the previous 12 months was 54.7%, which is only slightly above the national average of 52.5%. However, as discussed later, Tameside has the single worst emergency hospital admissions for Asthma in England.

Overall, the data from Fingertips OHID suggests that Tameside has a higher prevalence of long-term conditions compared to the national average, with specific conditions such as Asthma, diabetes, COPD, and cardiovascular disease being more prevalent or less under control. The data also suggests that there may be room for improvement in the management of long-term conditions in the area, particularly for Asthma.

Secondary Care

Secondary care, which is sometimes known as 'hospital and community care', can either be planned (elective) care such as a pre-planned operation, or urgent and emergency care such as treatment for a fracture. The overwhelming majority of secondary care takes place in a hospital, whether specialist (such as an eye hospital) or generalist which deals with all emergencies and an array of speciality areas. The main aim is for individuals in Tameside wherever possible to seek appointments and treatment within the primary care area, only moving to secondary care where required or in an absolute emergency.

Fingertips - Emergency Hospital Admissions, Planned Admissions and Condition specific Admissions

Indicator	Period	Tameside			Region	England	England		
		Recent Trend	Count	Value	Value	Value	Worst	Range	Best
Violent crime - hospital admissions for violence (including sexual violence)	2018/19 - 20/21	–	355	52.9	61.6	41.9	116.8		12.0
Emergency Hospital Admissions for Intentional Self-Harm	2021/22	–	425	184.4	190.3	163.9	425.7		47.9
Emergency hospital admissions due to falls in people aged 65 and over	2021/22	–	755	1,989	2,320	2,100	3,272		1,394
Emergency hospital admissions due to falls in people aged 65 to 79	2021/22	–	315	1,032	1,140	993	1,674		687
Emergency hospital admissions due to falls in people aged 80 plus	2021/22	–	440	4,764	5,744	5,311	8,251		3,354
Emergency readmissions within 30 days of discharge from hospital	2020/21	–	3,880	14.9%	15.0%	15.5%	20.0%		5.4%
Emergency hospital admissions in under 5 years old, crude rate	2016/17 - 20/21	–	9,385	218.4	-	140.7	273.4		37.9
Emergency hospital admissions for injuries in under 15 years old, crude rate	2016/17 - 20/21	–	2,730	127.8	-	92.0	161.6		48.5
Emergency hospital admissions for injuries in 15 to 24 years old, crude rate	2016/17 - 20/21	–	1,865	151.5	-	127.9	314.8		58.0
Emergency hospital admissions for all causes, all ages, standardised admission ratio ⚠	2016/17 - 20/21	–	-	122.6	-	100.0	161.8		62.4
Emergency hospital admissions for coronary heart disease, standardised admission ratio ⚠	2016/17 - 20/21	–	-	150.5	-	100.0	186.1		53.1
Emergency hospital admissions for stroke, standardised admission ratio ⚠	2016/17 - 20/21	–	-	125.9	-	100.0	149.1		62.7
Emergency hospital admissions for Myocardial Infarction (heart attack), standardised admission ratio ⚠	2016/17 - 20/21	–	-	137.1	-	100.0	174.2		44.9
Emergency hospital admissions for Chronic Obstructive Pulmonary Disease (COPD), standardised admission ratio ⚠	2016/17 - 20/21	–	-	172.9	-	100.0	222.7		31.6
Emergency hospital admissions for intentional self harm, standardised admission ratio ⚠	2016/17 - 20/21	–	-	123.4	-	100.0	229.7		19.2
Emergency hospital admissions for hip fracture in persons 65 years and over, standardised admission ratio ⚠	2016/17 - 20/21	–	-	121.9	-	100.0	137.8		66.2
Emergency hospital admissions for COPD (35+)	2019/20	→	955	765	536	415	1,068		163

Indicator	Period	Tameside			Region	England	England		
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Hospital admissions for alcohol attributable conditions, (Broad definition) ⚠	2016/17 - 20/21	–	21,664	122.2	-	100.0	184.7		61.1
Hospital admissions for dental caries (0 to 5 years)	2018/19 - 20/21	–	170	328.0	332.8	220.8	7.5		931.3
Smoking attributable hospital admissions (new method). This indicator uses new set of attributable fractions, and so differ from that originally published.	2019/20	↓	2,340	1,862	1,540	1,398	3,071		327
Inpatient stays in secondary mental health services, per 100,000 (All ages)	2019/20	–	625	286	255	241	556		102
Inpatient stays in secondary mental health services, per 100,000 (<18 yrs)	2019/20	–	15	32	32	53	1,529		14
Hip fractures in people aged 65 and over	2021/22	–	225	582	600	551	741		351
Hip fractures in people aged 65 to 79	2021/22	–	85	273	264	236	371		122
Hip fractures in people aged 80 and over	2021/22	–	140	1,480	1,574	1,466	1,897		922
Hospital admissions caused by unintentional and deliberate injuries in children (aged 0 to 14 years)	2021/22	–	455	105.6	105.0	84.3	162.2		38.8
Hospital admissions caused by unintentional and deliberate injuries in young people (aged 15 to 24 years)	2021/22	–	285	116.0	124.7	118.6	252.2		53.3
Ectopic pregnancy admissions rate / 100,000	2020/21	→	50	118.7	86.5	89.5	170.6		0.0
Hospital admissions due to substance misuse (15 to 24 years)	2018/19 - 20/21	–	70	95.0	106.0	81.2	229.4		16.9
Hospital admissions for asthma (under 19 years)	2021/22	–	235	438.0	181.7	131.5	438.0		47.0
Hospital admissions for mental health conditions (<18 yrs)	2021/22	–	50	97.8	100.2	99.8	355.1		33.3
Hospital admissions as a result of self-harm (10-24 years)	2021/22	–	-	400.0	474.0	427.3	1,051.7		127.6
Hospital admissions caused by unintentional and deliberate injuries in children (aged 0 to 4 years)	2021/22	–	170	125.6	129.7	103.6	204.5		42.0
Hospital admission rate due to liver disease (Persons)	2020/21	→	250	115.1	140.2	124.3*	264.4		64.1
Hospital admission rate due to liver disease (Male)	2020/21	→	130	123.9	180.0	156.4*	362.9		77.9
Hospital admission rate due to liver disease (Female)	2020/21	→	120	107.4	103.3	94.4*	203.1		39.0
Hospital admission rate for alcoholic liver disease (Persons)	2020/21	→	110	50.8	58.6	45.5*	143.5		9.8
Hospital admission rate for alcoholic liver disease (Male)	2020/21	→	50	45.6	75.3	61.7*	242.6		16.5
Hospital admission rate for alcoholic liver disease (Female)	2020/21	→	60	55.7	42.9	30.1*	89.2		8.3

In the latest annual report, Tameside and Glossop Integrated Care NHS Foundation Trust (TGICFT or Trust) stated that for another year, the Trust experienced serious disruption because of the Covid-19 pandemic. At the same time, demand upon the Trust's Emergency Department significantly increased, with a 34% rise in attendances (when compared to the year 2020/21). As was the case in 2020/21, the Trust was forced to undertake fewer operations, in order to reduce the demands upon its clinical services, meaning that many patients in Tameside have had to wait longer for their surgery. The Trust is now making progress in restoring activity to pre-pandemic levels, with an increase of 43% in the number of operations conducted in 2021/22 (when compared to 2020/21) and a significant reduction in the number of patients experiencing long waiting times (Tameside and Glossop Integrated Care Foundation Trust, 2021/22).

Services in the Trust and broadly speaking across hospitals in general, faced several challenges, including staff shortages, increasing demand for services, and the need for better integration of services which has been apparent both pre and post pandemic. The integration of the local ICB is hoped to address some of the challenges around better integration of services. Furthermore in reports from Trust highlighted the need for greater investment in primary care services to meet the growing demand for services and improve patient outcomes with the hope in reducing demand in the secondary care settings.

Tertiary and Community Care

Tameside and Glossop Integrated Care NHS Foundation Trust is the main provider of tertiary healthcare services in Tameside and offers a wide range of services, including hospital care, community care and mental health services.

Tertiary care refers to specialised healthcare services that are provided to patients with complex medical conditions requiring advanced diagnostic and treatment options. Tameside Hospital offers a range of specialties in services, including cardiology, respiratory medicine, gastroenterology, orthopaedics, and neurology. The hospital has a team of highly skilled consultants and healthcare professionals who work together to provide high-quality care to patients. In addition to providing inpatient care, the hospital also offers outpatient clinics and day surgery services.

In addition to tertiary and general medical services, community care in Tameside also includes community nursing and health visiting. This refers to healthcare services that are provided outside of hospitals, typically in the patient's home or in community-based settings. Tameside and Glossop Integrated Care NHS Foundation Trust provide a wide range of community care services, including district nursing, Health Visiting,

community therapy, palliative care, and intermediate care. Community nursing services provide care and support to people in their homes, while health-visiting services focus on promoting the health and wellbeing of children and families. Tameside Council and Sub Integrated Care Board and voluntary organisations to provide social care services, such as home care and support for carers. Additionally both children's and adult services provided by Tameside assist with social care and disability equipment.

Pharmacy services provide advice and support on medication use and management and specific services such as emergency contraception and needle exchanges. More information around Pharmacies can be found in the Pharmaceutical Needs Assessment, (Tameside Council, 2022).

The following indicators highlight a high-level overview of tertiary and community care within Tameside. The indicators are not exhaustive and focus mainly on the feedback given by service users via surveys in relation to social care. For a more comprehensive look at both adult social care and children's social care please see the aging well needs assessment (Sarah Newsam, 2022), Special Educational Needs and Disability Needs Assessment (Tameside Council, 2020) and Children and Young Persons needs assessment (ICB, 2022).

Fingertips – Tertiary and Community Care Indicators

Indicator	Period	Tameside			Region	England	England		
		Recent Trend	Count	Value	Value	Value	Worst	Range	Best
Proportion of New Birth Visits (NBVs) completed within 14 days	2021/22	↑	2,305	91.9%	85.7%	82.7%	9.5%		99.0%
Proportion of infants receiving a 6 to 8 week review	2021/22	→	2,234	89.0%	85.0%	81.6%	5.6%		99.8%
Proportion of children receiving a 12-month review	2021/22	↓	2,319	92.2%	85.8%	82.0%	22.2%		99.1%
Proportion of children who received a 2-2½ year review	2021/22	→	2,548	90.8%	79.9%	74.1%	6.9%		98.8%
Proportion of children aged 2-2½yrs receiving ASQ-3 as part of the Healthy Child Programme or integrated review	2021/22	→	2,391	92.3%	93.5%	90.3%	31.5%		100%
Attended contacts with community and outpatient mental health services, per 100,000 (All ages)	2019/20	–	72,830	32,756	31,759	30,674	10,646		64,510
Attended contacts with community and outpatient mental health services, per 100,000 (<18 yrs)	2019/20	–	18,065	37,880	30,183	28,395	7,544		71,697
New referrals to secondary mental health services, per 100,000 (All ages)	2019/20	–	16,060	7,241	7,637	6,897	1,652		14,059
New referrals to secondary mental health services, per 100,000 (<18 yrs)	2019/20	–	3,575	7,434	7,101	6,977	1,942		18,214
Social Isolation: percentage of adult social care users who have as much social contact as they would like (18+ yrs)	2021/22	–	-	36.3%	40.7%	40.6%	24.3%		52.5%
Social Isolation: percentage of adult social care users who have as much social contact as they would like (65+ yrs)	2021/22	→	-	31.6%	38.6%	37.3%	13.6%		54.5%
Depression and anxiety among social care users: % of social care users ⚠	2018/19	–	-	43.1%	-	50.5%	63.6%		38.5%
Proportion of people who use services who have control over their daily life	2019/20	–	2,110	77.3%	78.7%	77.3%	63.0%		92.4%
Percentage of people aged 65 and over who were still at home 91 days after discharge from hospital into reablement services	2021/22	↓	197	73.2%	86.0%	81.8%	31.9%		100.0%
Percentage of people aged 65 and over offered reablement services following discharge from hospital.	2021/22	↓	269	4.3%	2.7%	2.8%	0.0%		11.9%
Proportion of people who use services who feel safe	2019/20	–	1,975	72.4%	70.2%	70.2%	56.6%		91.0%
Satisfaction with social care protection: % of service users	2017/18	–	-	83.1%	85.7%	86.3%	65.7%		95.2%
Social Isolation: percentage of adult carers who have as much social contact as they would like (18+ yrs)	2021/22	–	80	26.4%	28.7%	28.0%	16.0%		43.2%
Social Isolation: percentage of adult carers who have as much social contact as they would like (65+ yrs)	2021/22	–	35	26.1%	30.9%	28.8%	14.4%		45.4%
Carer-reported quality of life score for people caring for someone with dementia	2018/19	–	-	7.40	7.30	7.30	6.10		8.40
Percentage of people aged 65 and over using social care who receive self-directed support, and those receiving direct payments	2021/22	–	1,281	100.0%	91.9%	93.2%	2.3%		100.0%
Percentage of adult social care service users have control over their daily lives, age 65+	2021/22	→	1,290	70.7%	75.0%	73.3%	57.4%		87.2%
Percentage of adult social care service users satisfied with care and support services, age 65+	2021/22	–	970	53.2%	61.7%	61.8%	42.2%		80.9%

Overall, Tameside is significantly better than the England average around Health Visiting activity, reablement and carer reported quality of life, for those caring with someone who has dementia. However, Tameside is significantly worse for at home 91 days after hospital discharge, service user care satisfaction and social contact.

In relation to healthcare, primary care services in Tameside play a crucial role in providing healthcare services to the local population. However, the area faces challenges in addressing health inequalities, particularly in the management of long-term conditions. The data shows that Tameside has higher rates of chronic illness and poor health outcomes compared to the national average, particularly for conditions such as Asthma, diabetes, COPD, and cardiovascular disease. The need for a more comprehensive and integrated approach to healthcare delivery is crucial in ensuring that primary care services are tailored to the needs of the local population. The data also highlights that demand for secondary care services has significantly increased, particularly during the Covid-19 pandemic, and this has had an impact on the delivery of services. More work is needed to improve outcomes for people in Tameside, particularly in the area of long-term condition management and preventative care.

Mortality and Premature Mortality

According to a report by Public Health England (now Office of Health Improvement and Disparities), the age-standardised mortality rate in Tameside was higher than the national average between 2015 and 2017 (Public Health England, 2019). The report also found that Tameside had higher rates of premature mortality, cardiovascular disease, and cancer compared to the national average.

The Office for Heath Improvement and Disparities have identified the top five causes of premature mortality in Tameside as cardiovascular disease, respiratory disease, cancer, liver disease, and suicide. The causes of premature mortality were all linked to lifestyle factors such as smoking, alcohol consumption, and poor diet, so therefore preventable causes.

A study published in the Journal of Public Health found that Tameside had a higher prevalence of obesity, physical inactivity, and smoking compared to the national average (Lambert et al., 2015). The study also found that Tameside had higher rates of hospital admissions for chronic conditions such as asthma, diabetes, and chronic obstructive pulmonary disease (COPD).

The National Child Measurement Programme (NCMP) found that Tameside had higher rates of childhood obesity compared to the national average (NHS Digital, 2019). The NCMP also found that Tameside had higher rates of overweight and obese children in reception year (ages 4-5) and year 6 (ages 10-11). This is an indication of health later on in life with Childhood Obesity laying the foundation for unhealthy practices as an adult.

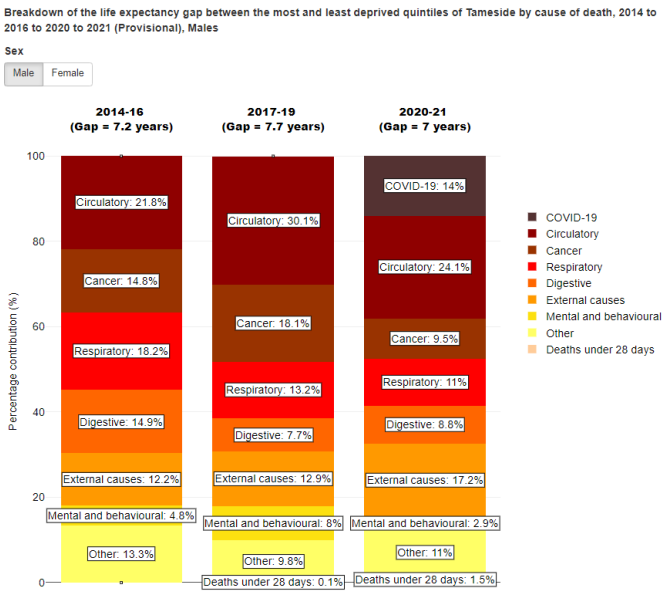
The challenges facing public health in Tameside are vast and the need for targeted interventions to address these challenges is necessary. By addressing lifestyle factors such as smoking, alcohol consumption, and poor diet, and promoting physical activity and healthy weight, it is possible to improve health outcomes and reduce the burden of chronic illness in the area.

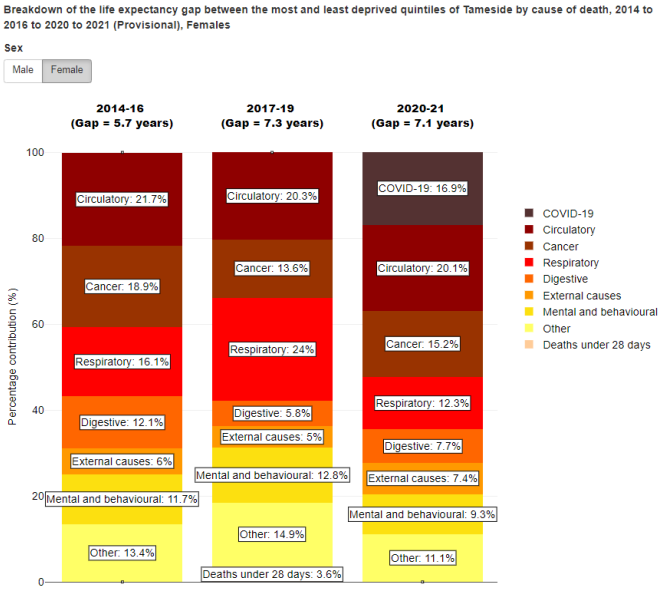
Fingertips – Premature Mortality Indicators

Indicator	Period	North West			England			
		Recent Trend	Count	Value	Value	Worst	Range	Best
E01 - Infant mortality rate New data	2019 - 21	–	1,039	4.4	3.9	5.6		2.9
E03 - Under 75 mortality rate from causes considered preventable New data	2021	–	14,754	222.2	183.2	228.2		146.1
E04a - Under 75 mortality rate from all cardiovascular diseases New data	2021	–	6,175	92.8	76.0	92.8		63.1
E04b - Under 75 mortality rate from cardiovascular diseases considered preventable New data	2021	–	2,464	37.0	30.2	37.0		24.2
E05a - Under 75 mortality rate from cancer New data	2021	–	9,074	136.0	121.5	139.4		110.2
E05b - Under 75 mortality rate from cancer considered preventable New data	2021	–	3,927	58.8	50.1	62.3		43.3
E06a - Under 75 mortality rate from liver disease New data	2021	–	1,932	29.3	21.2	29.3		17.5
E06b - Under 75 mortality rate from liver disease considered preventable New data	2021	–	1,707	25.9	18.9	26.1		15.1
E07a - Under 75 mortality rate from respiratory disease New data	2021	–	2,363	35.3	26.5	36.7		21.2
E07b - Under 75 mortality rate from respiratory disease considered preventable New data	2021	–	1,362	20.4	15.6	23.7		12.1
E08 - Mortality rate from a range of specified communicable diseases, including influenza New data	2021	–	834	11.8	9.4	11.8		7.4
E09a - Premature mortality in adults with severe mental illness (SMI) New data	2018 - 20	–	20,765	135.3	103.6	144.0		83.7
E09b - Excess under 75 mortality rate in adults with severe mental illness (SMI) New data	2018 - 20	–	-	364.6%	389.9%	457.0%		344.2%
E10 - Suicide rate	2019 - 21	–	2,177	11.4	10.4	13.0		7.2

Tameside has significantly worse premature mortality rates than the England average and Tameside has some of the worst premature mortality rates owing to liver disease, cardiovascular disease and communicable diseases. Ultimately, these indicators are the end story of the health in Tameside as a whole, and targeted interventions at the preventable stages will reduce the amount of people dieing prematurely in our Borough.

Scarf Charts –Life Expectancy Gap between Most and Least Deprived Areas of Tameside





In terms of age and cause of death, it is important to note that deprivation can have a significant impact on health outcomes. People living in more deprived areas are more likely to experience poor health and have a shorter life expectancy compared to those in less deprived areas. In addition, in terms of age, the mortality rate is higher in the most deprived areas for all age groups, with the highest difference observed for people under the age of 75. This suggests that people living in more deprived areas are more likely to die prematurely.

As for cause of death, there is a significant gap between the most and least deprived areas in Tameside. The most deprived areas have higher mortality rates for a range of causes of death, including circulatory diseases, respiratory diseases, cancer, and external causes of death (such as accidents and suicides). The gap is particularly large for deaths due to respiratory diseases, which are strongly associated with deprivation and poor living conditions. This has only increased and become even more noticeable since the COVID-19 pandemic.

In conclusion, Tameside faces significant public health challenges around premature mortality, with rates of cardiovascular disease, cancer, and obesity being significantly higher when compared to the national average. These challenges are linked to lifestyle factors such as smoking, alcohol consumption, and poor diet, which are preventable causes. The impact of deprivation on health outcomes is also significant, with people living in more deprived areas more likely to experience poor health and have a shorter life expectancy. Targeted interventions are necessary to address these challenges, such as promoting healthy lifestyle choices and improving living conditions. By reducing the burden of chronic illness, it is possible to improve health outcomes and reduce premature mortality in Tameside although some of the measures will not be apparent for a number of years.

Conclusions and Areas to Focus Upon

In conclusion, throughout the assessment, the data highlights some concerning health disparities in Tameside, including the fact that females have fewer years in good health/disability free than males, despite having a longer life expectancy.

The healthy life expectancy and disability free life expectancy are also several years lower than the state pension age. The recommendations put forward include a needs assessment to inform the re-commission of substance misuse services, targeting blue-collar workers to improve their health outcomes, and working on communication skills in children in the first 1000 days of their lives. Work around communication skills with children/babies in the first 1000 days is recommended, as currently Tameside is significantly worse in this area. Communication skills are vital in this stage of development and with the Children's Hubs being established within Tameside, part of the programme may need to reflect the need for this.

Improving access to post-16 education and supporting small to medium enterprises in the area could also provide more job opportunities and economic growth. In relation to water quality, Fluoridation levels remain significantly lower than elsewhere in the UK and residents of Tameside experience poor oral health outcomes. Further investigation may be required in this area. Additionally, addressing air quality and increasing physical activity through schemes such as the sale of pre-loved bicycles can have significant benefits for the health of Tameside residents. Further investigation is required to understand why screening uptake is low, and the fluoridation levels and management of long-term conditions such as Asthma require attention. By implementing these recommendations, Tameside can work towards improving the health and wellbeing of the whole area.

Recommendations

In summary, the suggested further work to be carried out as highlighted in the document is as follows:

- Work with system partners across Tameside through forums like the Health & Wellbeing Board to monitor the impact of disproportionate adverse health outcomes for the population and how health inequalities affect long term health. This approach should retain a focus on preventative approaches and tackling the wider determinants of health.
- Embed a system wide approach to prioritising targeted interventions in the most deprived communities across Tameside, as most adverse health outcomes and poor performance indicators (e.g. uptake of interventions) are worst in the more deprived parts of the borough

- Tackle the harms of alcohol through available local forums including the Health & Wellbeing Board and the Community Safety Partnership. This should also consider the opportunities to tackle alcohol harms via public health commissioned substance misuse services; local healthcare services; local licensing processes; updating local needs assessment data; and having a dedicated local strategic partnership.

- Improve the proactive identification and management of residents who have risk factors and long term conditions to improve their long term health outcomes. This should include a focus on the key drivers of preventable ill health in Tameside including obesity, alcohol consumption, inactivity and tobacco. Focusing on these risk factors, or *secondary prevention* should include tackling the inequalities in access to support that certain groups face. This should also include work with primary care and community services to optimise the approach to early identification and proactive management of people with existing long term conditions. These approaches will support reductions in Tameside's very high levels of early, preventable mortality.

- Make smoking history - by working across Greater Manchester with existing programmes as well as locally with health promotion approaches; enforcement of regulations to limit underage sales and illicit tobacco availability; and a targeted smoking cessation offer, focused on groups with higher smoking prevalence and poorer outcomes. A strategic focus on improving education and skills development as well as employment in Tameside at relevant forums including the Health & Wellbeing Board and Inclusive Growth Board. Specific actions within this work should include a 'Work & Skills' needs assessment to understand more about the level of challenges, what is already in place in Tameside and evidence based approaches to improve this. A focus on sustainable resources and support for people to get into and stay in good work, with a focus on young people not in education employment or training; support for small to medium enterprises across Tameside; and work to encourage increased wages in the borough are also key actions.

- Continue to work with partners to deliver the GM Clean Air Plan to support reduced emissions and particulate matter. Additionally, strategic drivers around physical activity and active travel should continue including recent examples delivered such as the pre-loved bike sales run by the Population Health team.

- A review of health protection data and creation of a dashboard to monitor all areas under the remit of the Tameside Health Protection Board. Areas of focus include national screening programmes and work to address lower uptake and inequalities in uptake; and immunisation uptake, particularly seasonal immunisations. For both screening and immunisations, a particular focus should be placed on targeting and approaches for more deprived communities.

- It should be noted that for Asthma Tameside has the worse directly standardised rate for hospital admission in England. More work around prevention, proactive management (including in primary care), and raising awareness of this is needed to further explore and reduce this.
- Continue to improve borough-wide approaches to improving population mental health & wellbeing including ‘making every contact count’ approaches across workforces; general awareness raising, education and promotion; and training opportunities such as Connect 5 training, in order to reduce the prevalence of low-level mental health disorders such as depression and anxiety and support people at an earlier stage.
- Adopt a system wide food strategy for Tameside which aims to address the inequalities in food poverty and food insecurity across the borough which impact on households in the most deprived communities. One upstream area of focus should be around policies to tackle high density of hot food takeaways in certain areas (particularly in more deprived areas and those with higher rates of childhood obesity).

References

ASH. (2023). *Ready Reckoner.* Retrieved from ASH: https://ash.org.uk/resources/view/ash-ready-reckoner

BMJ. (2022). Long distance airborne transmission of SARS-CoV-2: rapid systematic review. *The BMJ*, 1.

Chandra L. Jackson, M. A. (2016). *Sexual orientation identity disparities in health behaviors, outcomes, and services use among men and women in the United States: a cross-sectional study.* Retrieved from BMC: https://rdcu.be/c8t8j

Department for Business, I. &. (2008). *Fair Treatment at Work Survey*. Retrieved from GOV.UK: https://www.gov.uk/government/publications/fair-treatment-at-work-report-findings-from-the-2008-survey

Department of Health and Social Care. (2020, March 5). *Coronavirus (COVID-19) listed as a notifiable disease*. Retrieved from GOV.UK: https://www.gov.uk/government/news/coronavirus-covid-19-listed-as-a-notifiable-disease

Disability Rights UK. (2020, February). *Nearly half of everyone in poverty is either a disabled person or lives with a disabled person*. Retrieved from Diability Rights UK: https://www.disabilityrightsuk.org/news/2020/february/nearly-half-everyone-poverty-either-disabled-person-or-lives-disabled-person

Gabriel Scally, B. J. (2020, May 15). The UK's public health response to covid-19. *The BMJ*, p. 1.

Greater Manchester Clean Air Plan. (2023). *Greater Manchester Clean Air Plan.* Retrieved from Clean Air Greater Manchester: https://cleanairgm.com/clean-air-plan/

Home Office. (2012). *Alcohol Strategy.* Retrieved from GOV.UK: https://www.gov.uk/government/publications/alcohol-strategy

House of Commons, Health and Social Care Committee. (2019, 02 12). *First 1000 days of life.* Retrieved from Parliment.UK: https://publications.parliament.uk/pa/cm201719/cmselect/cmhealth/1496/1496.pdf

ICB, T. C. (2022). *Tameside Council.* Retrieved from JSNA: https://www.tameside.gov.uk/TamesideMBC/media/PublicHealth/CYP-JSNA-final-report.pdf

Jun She, J. J. (2020). 2019 novel coronavirus of pneumonia in Wuhan, China: emerging attack and management strategies. *National Library of Medicine*, 1.

Lancet, Public Health - Victoria J McGowan, Clare Bambra. (2022). *COVID-19 mortality and deprivation: pandemic, syndemic, and endemic health inequalities.* Retrieved from Lancet: https://www.thelancet.com/action/showPdf?pii=S2468-2667%2822%2900223-7

Local Government Association. (2021). *A review of research into vaccine uptake in the UK*. Retrieved from LGA: https://www.local.gov.uk/our-support/coronavirus-information-councils/covid-19-service-information/covid-19-vaccinations/behavioural-insights/resources/research

Mahase, E. (2020). Covid-19: death rate is 0.66% and increases with age, study estimates. *The BMJ*, 1.

Melika Lotfi, M. R. (2020). COVID-19: Transmission, prevention, and potential therapeutic opportunities. *ScienceDirect*, 1-3.

MHCLG. (2019). *English indices of deprivation 2019*. Retrieved from GOV.UK: https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019

Miyazawa, K. (2005, July). *Growth and Inequality: A Demographic Explanation*. Retrieved from London School of Economics: http://eprints.lse.ac.uk/6546/1/Growth_and_Inequality_A_Demographic_Explanation.pdf

Office for Health Improvement and Disparities. (2023). *Fingertips Public Health Profiles.* Retrieved from Office for Health Improvement and Disparities: https://fingertips.phe.org.uk/

OHID. (2022, December). *Fingertips, Improving health outcomes for vulnerable children and young people*. Retrieved from Office for Health improvement & Disparities: https://fingertips.phe.org.uk/profile/child-

health-profiles/data#page/13/gid/1938133228/pat/6/ati/302/are/E08000008/iid/92196/age/2/sex/4/cat/-1/ctp/-1/yrr/3/cid/4/tbm/1

Oxford University Population Health. (2022, Jan). *New genetic study confirms that alcohol is a direct cause of cancer.* Retrieved from Oxford Population Health: https://www.ndph.ox.ac.uk/news/new-genetic-study-confirms-that-alcohol-is-a-direct-cause-of-cancer

Patrick J. Lillie, a. A. (2020). Novel coronavirus disease (Covid-19): The first two patients in the UK with person to person transmission. *J Infect*, 1-3.

Peng Zhou, X.-L. Y.-G.-R.-L.-D.-D.-Q.-R.-S. (2020). A pneumonia outbreak associated with a new coronavirus of probable bat origin. *Nature*, 1.

Public Health England. (2018). *Air pollution: a tool to estimate healthcare costs.* Retrieved from GOV.UK: https://www.gov.uk/government/publications/air-pollution-a-tool-to-estimate-healthcare-costs

Sarah Newsam, S. f. (2022). *Tameside Council.* Retrieved from JSNA: https://www.tameside.gov.uk/TamesideMBC/media/PublicHealth/Ageing-Well-in-Tameside-Needs-Assessment.pdf

Small Area Health Statistics Unit (MRZC-PHE and Imperial Colledge London). (2023). *THE ENVIRONMENT AND HEALTH ATLAS FOR ENGLAND AND WALES.* Retrieved from Small Area Health Statistics Unit: https://www.envhealthatlas.co.uk/homepage/

Tameside and Glossop Integrated Care Foundation Trust. (2021/22). *T&GICFT.* Retrieved from Annual Reports: https://www.tamesideandglossopicft.nhs.uk/application/files/3116/5667/2032/ARA_Tameside_Glossop_-_for_checking.pdf

Tameside Council. (2022). *Pharmaceutical Needs Assessment for Tameside.* Retrieved from Tameside Council: https://www.tameside.gov.uk/TamesideMBC/media/PublicHealth/Tameside-Pharmacy-Needs-Assessment-2022-25.pdf

Tameside Council, P. P. (2020). *Tameside Council.* Retrieved from JSNA: https://www.tameside.gov.uk/TamesideMBC/media/PublicHealth/Special-Educational-Needs-and-Disability-JSNA-final!.pdf

Tameside MBC. (2023). *Tameside Council.* Retrieved from Pest Control: https://www.tameside.gov.uk/pestcontrol

Tameside MBC. (2023). *Tameside Council.* Retrieved from Environmental Services: https://www.tameside.gov.uk/servicestandards

Tameside MBC. (2023). *Waste Services.* Retrieved from Tameside Council: https://www.tameside.gov.uk/refuseandrecycling

The Food Foundation. (2018). *Affordability of the UK's Eatwell Guide.* Retrieved from The Food Foundation: https://foodfoundation.org.uk/publication/affordability-uks-eatwell-guide

The Health Foundation. (2021). *Unequal Pandemic, Fairer Recovery.* The Health Foundation.

The Health Foundation. (2023). *Housing.* Retrieved from The Health Foundation: https://www.health.org.uk/evidence-hub/housing?gclid=Cj0KCQjwuLShBhC_ARIsAFod4fKYAJro9Ro7FYaT4PTsacdyjOrhesM1DuKsNnCWeRR52-tuewNk5k0aAsQiEALw_wcB

UCL Insitiute of Health Equity. (2015). *The impact of adverse experiences in the home on the health of children and young people, an inequalities in prevalence and effects.* Retrieved from https://www.instituteofhealthequity.org/: https://www.instituteofhealthequity.org/resources-reports/the-impact-of-adverse-experiences-in-the-home-on-children-and-young-people/impact-of-adverse-experiences-in-the-home.pdf

UK Government. (2020). *The Health Protection (Coronavirus, Restrictions) (England) Regulations 2020.* Legislation.gov.uk.

United Utilities. (2023). *Drinking Water Quality.* Retrieved from United Utilities: https://www.unitedutilities.com/help-and-support/drinking-water-quality

United Utilities. (2023). *Saving Water.* Retrieved from United Utilities: https://www.unitedutilities.com/help-and-support/saving-water/

United Utilities. (n.d.). *Drinking Water Quality Reports.* Retrieved from United Utilities: https://www.unitedutilities.com/help-and-support/your-water-supply/your-water/water-quality/

Visformatics. (2019). *Visformatics – Written evidence (FPO0061).* Retrieved from Parliment.uk: https://committees.parliament.uk/writtenevidence/105067/html/

WHO. (2020). *WHO Director-General's opening remarks at the media briefing on COVID-19 - 11 March 2020*. Retrieved from WHO: https://www.who.int/director-general/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020